National Library
of Canada

Acquisitions and
Bibliographic Services Branch

395 Wellington Street
Ottawa, Ontario
K1A 0N4

Bibliothèque nationale
du Canada

Direction des acquisitions et
des services bibliographiques

395, rue Wellington
Ottawa (Ontario)
K1A 0N4

Your file Votre référence

Our file Notre référence

NOTICE

The quality of this microform is heavily dependent upon the quality of the original thesis submitted for microfilming. Every effort has been made to ensure the highest quality of reproduction possible.

If pages are missing, contact the university which granted the degree.

Some pages may have indistinct print especially if the original pages were typed with a poor typewriter ribbon or if the university sent us an inferior photocopy.

Reproduction in full or in part of this microform is governed by the Canadian Copyright Act, R.S.C. 1970, c. C-30, and subsequent amendments.

AVIS

La qualité de cette microforme dépend grandement de la qualité de la thèse soumise au microfilmage. Nous avons tout fait pour assurer une qualité supérieure de reproduction.

S'il manque des pages, veuillez communiquer avec l'université qui a conféré le grade.

La qualité d'impression de certaines pages peut laisser à désirer, surtout si les pages originales ont été dactylographiées à l'aide d'un ruban usé ou si l'université nous a fait parvenir une photocopie de qualité inférieure.

La reproduction, même partielle, de cette microforme est soumise à la Loi canadienne sur le droit d'auteur, SRC 1970, c. C-30, et ses amendements subséquents.

Canada

UNIVERSITY OF ALBERTA

EXPLORING NARRATIVES OF RELATIONSHIP IN INTENSIVE CARE NURSING

BY

ANN T. SCHWEITZER ©

A thesis submitted to the Faculty of Graduate Studies and Research
in partial fulfillment of the requirements for the degree of
Doctor of Philosophy

DEPARTMENT OF SECONDARY EDUCATION

Edmonton, Alberta

Spring 1994

National Library of Canada
Acquisitions and Bibliographic Services Branch
395 Wellington Street
Ottawa, Ontario
K1A 0N4

Bibliothèque nationale du Canada
Direction des acquisitions et des services bibliographiques
395, rue Wellington
Ottawa (Ontario)
K1A 0N4

Your file Votre référence

Our file Notre référence

The author has granted an irrevocable non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of his/her thesis by any means and in any form or format, making this thesis available to interested persons.

L'auteur a accordé une licence irrévocable et non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de sa thèse de quelque manière et sous quelque forme que ce soit pour mettre des exemplaires de cette thèse à la disposition des personnes intéressées.

The author retains ownership of the copyright in his/her thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without his/her permission.

L'auteur conserve la propriété du droit d'auteur qui protège sa thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

ISBN 0-612-11361-2

Canadä

UNIVERSITY OF ALBERTA

RELEASE FORM

NAME OF AUTHOR:	ANN T. SCHWEITZER
TITLE OF THESIS:	EXPLORING NARRATIVES OF RELATIONSHIP IN INTENSIVE CARE NURSING
DEGREE:	DOCTOR OF PHILOSOPHY
YEAR THIS DEGREE GRANTED:	1994

Permission is hereby granted to the University of Alberta Library to reproduce single copies of this thesis and to lend or sell such copies for private, scholarly or scientific research purposes only.

The author reserves all other publication and other rights in association with the copyright in the thesis, and except as hereinbefore provided neither the thesis nor any substantial portion thereof may be printed or otherwise reproduced in any material form whatever without the author's prior written permission.

Ann T. Schweitzer

111 Simcoe Crescent
Komoka, Ontario
N0L 1R0

Release Form

May 12, 1992

Dr. Debra Shogan
Dept. of Recreation and Leisure Studies
University of Alberta
Edmonton Alberta
T6G 2H9

Dear Dr. Shogan:

Please consider this form your authorization to publish my article, What Do We Mean By 'Caring'? A Nurse educator's Reflections in the reader, *Feminist Ethics*, to be published by Canadian Scholars' Press Inc. (CSPI) I affirm that no other person has any copyright or other right in the work or any part of it. The article has not previously been published. The work does not disclose information received in confidence or contain any material which is libelous or otherwise actionable.

I understand that copyright in the reader shall be held jointly by the editors, authors and CSPI provided that CSPI shall have the exclusive worldwide right to do and to authorize the reproduction of the reader in whole or in part; prepare derivative works based on the reader; distribute copies of the reader to the public by any means including sale, rental or lease; and public display of the reader.

★ Notwithstanding the above, I understand that I may incorporate the contents of my article submitted for the reader into other work that I may write, or rewrite the article for publication in another work.

DATED the 12 day of May, 1992

Ann T Schwartz

UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled Exploring Narrative of Relationship in Intensive Care Nursing submitted by Ann T. Schweitzer in partial fulfilment of the requirements for the degree of Doctor of Philosophy.

Dr. Terrance Carson
(supervisor)

Vangie Bergum
Dr. Vangie Bergum

Winnie Tomm
Dr. Winnifred Tomm

Jean Clandinin
Dr. Jean Clandinin

Dr. Kenneth Jacknicke

M. E. McHutchion
Dr. Edna McHutchion
(external examiner)

January 14, 1994
Date

DEDICATION

To the nurses who offered their narratives and understandings of how we create our relational lives as we imagine the possibilities in our professional practice.

ABSTRACT

This study explores the personal meanings that nurses give to their relationships with patients, patients' families and work colleagues in the context of the intensive care unit. The orientation of this research incorporated aspects of hermeneutic, feminist and postmodern thought.

The methodology centered on sequential small group sessions, conducted in an interactive dialogic manner. These group interviews offered the potential for a deeper probing of the experiences and a reciprocally educative encounter. Two groups, eight nurses in total, met many times over a three month period to reflect and discuss their own stories related to this aspect of our professional lives. We listened for themes that would offer us greater understanding. At times meanings were negotiated, at other times a *partage* of meaning was maintained. We endeavored to maintain subtlety and diversity in the narratives and in the interpretations of those accounts.

Two broad constellations of themes emerged and nurses spoke of the challenge in being positioned in the space between diverse images. At times they perceived themselves in the role of a caretaker characterized by a focus on tasks in which the self is involved in hierarchical relationships with instrumental, technological goals. Another image of self was that of self as a being in relationship. This image of self was characterized by more egalitarian interactions, responding to others in dynamic, responsive, respectful interactions. The focus was on being in touch with other persons in more humane, contextual encounters; the feeling of experiencing life in a bigger matrix.

The author then reflects on how nurse educators might respond to the call of these narratives. There is an exploration of the implication of living in (and educating for) a life which is positioned within an ambiguous, complex and often paradoxical world.

ACKNOWLEDGEMENTS

I wish to express my appreciation to Angela Law for her patient, efficient competence in assisting in the preparation of this manuscript.

I have benefited much from the wise guidance of Terry Carson. I admire and hope to emulate his role modelling as a respectful academic advisor. He has mastered the artful balance of letting be, insightful questions and thoughtful suggestions.

In my own life journey I have been graced by the company of individuals who have supported, challenged and inspired me. I thank you.

TABLE OF CONTENTS

LIBRARY RELEASE FORM
TITLE PAGE
SIGNED COMMITTEE APPROVAL PAGE
DEDICATION
ABSTRACT
ACKNOWLEDGEMENT
TABLE OF CONTENTS
LIST OF FIGURES

CHAPTER I - PROLOGUE: REMEMBERING WITH MARY 1

- The Roots of Nursing 2
- Encounter 4
- Response 5
- Embodied Caring 7
- The Space Between 9
- In Celebration 11

CHAPTER II - THE CONTEXT OF THE QUESTION 13

- Genesis of Wondering/Wandering 13
- Significance of the Question 16
- Theoretical Frameworks that Shape the Question 18
  - Influences from postmodern thought 20
  - Influences from hermeneutics 23
  - Influences from feminist thought 25
- The Process of Inquiry 28
  - Conduct of the research - the pilot study 29
  - Conversations from the critical care context 39
  - Some implications related to language and ethics 41
  - Our experience 45
  - Introducing the participants 48

CHAPTER III - AN OVERVIEW OF THE THEMES: SETTING THE STAGE 55

- Central Yet Marginal 55
- Constellation of themes 57
- To Know Where We're Coming From 58
  - Being there for others 59
  - Quest for challenges 63
  - A 'mature' perspective 67
  - Women are different 70
- The Tension Between Representations of Self.................. 76

CHAPTER IV - STORIES AND REFLECTIONS ON RELATIONSHIP 79

- Relationship with Patients and Their Families 79
  - We have come to wonder 79
  - "Intensive" care 79
  - Dilemma of response/ability 88
  - Dealing with the meaning of life and death 98

- Relationship with Nursing Colleagues 106
  - We have come to wonder 106
  - The violence of conformity 107
  - Brutality of one-up-man-ship 109
  - Protecting territory 111
  - An organic community 114
  - The inheritance 115
  - Perceptions of gender difference 117
  - Wondering about socialization 120
  - Responses to male behaviour 121

TABLE OF CONTENTS (Continued)

Page

Relationship with Head Nurses/Nursing Management 123
  We have come to wonder 123
  Abandoned 124
  Powerless 127
  The consequences of meager sustenance 130
  A preferred reality 132

Relationship with Physicians 135
  We have come to wonder 135
  Instrumental relationships 136
  Climate of blame 138
  The deference game 142
  He won't listen 143
  A struggle in language 145
  Confrontations: Alien worlds 149
  The desired difference 153

CHAPTER V - HEARKENING TO THE VOICES 157

Recalling the Themes 157
  Image of self as caretaker 157
  Image of self as a Being in relationship 160

Retelling in New Ways: Response to Vocation 162
  Be sensitive to language 163
  Encounter multiple realities with equanimity 165
  Explore preferred realities 168
  Stay rooted in reflective practice 171
  Write the marginal from a personal centeredness 173
  Choose person over persona 175
  Embrace the responsibility of responsiveness 178
  Learn to be present for myself 180
  Respect the sacred 183
  Never cease to wonder/wander 186

CHAPTER VI - EPILOGUE: RE/MEMBERING WITH NURSES 187

The Experience of This Journey 187
Re/Membering Life as a Nurse/Teacher 191
  The roots of nursing 192
  Encounter 193
  Response 194
  Embodied caring 194
  The space between 195
  In celebration 196

REFERENCES 197

LIST OF FIGURES

Page

Figure 1. The Tension Between Representations of Self 77

Figure 2. Image of Self as Caretaker 159

Figure 3. Image of Self as a Being in Relationship 161

CHAPTER I

PROLOGUE: REMEMBERING WITH MARY

The intent of this inquiry is to explore the understandings that nurses have about their relationships with patients, patients' families and work colleagues in their professional lives in the context of the intensive care unit.

Nurses, especially those who work in critical care settings, will tell you that the relationships that they have with others in their work setting both provide meaningful satisfaction to their lives and are often the source of pain, anger and frustration. I am a nurse educator. That vocation calls me to assist nurses as they learn to be more reflective in their professional practice. The understandings explored in this research can provoke additional thoughtfulness as we make choices in how we wish to be present to others. It is hoped that insights gained though this research will inspire us to create new possibilities in how we can truly care about ourselves and others. This inquiry values nurses experiences and their interpretation of those experiences as a source of knowledge.

I begin the text with a narrative of my experience a few years ago. These events marked the beginning of a more conscious journey toward understanding these relationships and the exploration of my own subjectivity in this context.

Throughout this dissertation *italics signify the voice of a storyteller*; standard font, the reflective interpretive voice of this author. In this first story I am both the storyteller and the reflective voice; later stories have other storytellers. The comments interspersed throughout the narratives and conversations are not intended to summarize the story. They represent an ongoing interpretation of the voices of the nurses as they speak of their lives. I listen to their words and phrases and respond from my own subject position. This position has been informed

---

A version of this chapter has been published. In D. Shogan (Ed.). (1992). A reader in feminist ethics. Toronto: Canadian Scholars Press.

by my own experiences and by reflection on writings in hermeneutics, feminist and postmodern thought. I will discuss later how this reflection intertwines with those of the other participants in this study.

The Roots of Nursing

It was 7:15 on a Sunday morning, my new white 'duty shoes' squeaked on the highly polished floors as I made my way down the hospital corridor to the Cardiac Intensive Care Unit. This journey was not a new experience; I had worked in this area for eighteen years, but today was different. Although I was a seasoned critical care nurse, the last 12 years had been spent either in being the clinical instructor for this unit or filling the role of unit administrator, I have always involved myself in bedside nursing even though it was not the main consumer of my professional time.

I had become restless with what I perceived to be a professional plateau; disillusioned with what I sensed to be an erosion and fading of personal visions; and frustrated in not finding ways for meaningful action toward worthwhile goals. Some might dismiss this as middle age crisis, but I was determined to try to return to my roots in order to rekindle a passion that seemed to be lukewarm.

As I entered the doors to the unit I was aware of a heightened sensation in my stomach and chest. Was this excitement or apprehension? Sometimes it is hard to tell the difference.

In preparation for morning report, I checked the assignment board. Usually I was the one making it out, but today, on the first day of my three month change of roles to staff nurse, I was looking to see what another had prescribed as my professional destiny for the day. I had been assigned to Mary Webster. Even before the night nurse's report, an experienced glance at Mary's room, her monitor and the thickness of her "nurses' notes" on the chart, let me know this would be a challenging day. It was clearer now that the feeling in my stomach was apprehension. I wasn't sure if this assignment represented my colleagues' concern to give me 'meaningful experiences' or a touch of covert revenge welcoming me back into the 'real world'.

During morning report, I learned that this 67 year old woman was a nurse, a teacher of nurses, recently retired to the west coast. My most grim predictions of the severity of Mary's condition were confirmed in the litany of ominous signs and symptoms of her physical state. The religion of my youth surfaced, each additional statement of her dire condition elicited from my heart the silent supplication "Lord hear our prayer!"

Mary had been admitted three hours earlier with a massive heart attack. The evidence from the electrocardiogram, the lab tests, the physiological parameters all conspired to display an inescapable picture. Mary was dying because she did not have enough uninjured heart muscle left to sustain life. I immediately put in a call for Mary's cardiologist. As Mary's 'health care team', Dr. White and myself needed to take stock of the situation and ourselves.

And yet I wonder - What is the experience of being a nurse in an intensive care unit?

At moments like these one wonders if this technological gift of "scientific certainty" is a blessing. The purpose of this kind of unit is thought by many to be the saving of lives. The cardiologists and the cardiology nurses spend years refining their knowledge and skills to apply the 'cutting edge' of technological advances to our patients. We are surrounded by the latest sophisticated drugs and equipment. We are conditioned like fire horses to respond to the sound of the bell and the smell of danger. There was nothing in our state of the art medical magic that would significantly change the outcome of this day for Mary. Today would challenge us to take a new and critical look at what we were doing.

I am a nurse - one who takes care of, looks after, or advises another. I had chosen to "return to my roots in order to rekindle a passion." How did I sense that I would clear my "vision" in returning to attend to a person who was ill? What "roots of nursing" did I seek?

Roots convey nourishment from the earth; they are the part that unites and gives stability--allowing a plant to grow. What inner or essential part did I hope to ignite with desire through this tending to, this caring for Mary? How did I aspire to arouse some remembrance of my lineage?

Encounter

After report, and before Dr. White had a chance to respond, I went to Mary's bedside. As I entered the room, I completed the checklist inventory that becomes automatic for the critical care nurse: four intravenous drips, each with the prescribed drug at the prescribed rate of infusion; the supplemental oxygen in place, without kinks nor moisture in the tubing; physiological monitor blipping and displaying numbers appropriately, all safety alarms functional; urinary output monitor reset and functioning; all emergency equipment present. On completion of this 90 second scrutiny of the accoutrements of the technological deity, I could return my attention to Mary.

As I went to her, leaning forward over the side rail to look into her face, she opened her eyes. "Hello Mary, my name is Ann. I will be your nurse for today." The simplicity of that meeting belied the intensity of what was to come--for both of us.

With a disarming candor she gazed into my eyes demanding the truth, "Am I going to die?" I took her hand, nodded slightly; our eyes still engaged, "Your heart has been badly injured by a heart attack, I'm afraid all indications are not very good..." "Damn!" she broke in. She closed her eyes. During the following five minutes of silence we continued to hold hands. Finally I said quietly "I will be your nurse all day, but is there anything you would like me to do now?"

Her eyes reopened, tears welling up to the brim; she silently shook her head. I offered a sip of cold ginger ale, placed kleenex within reach and helped her rearrange her body on her side, curled up. I snuggled a pillow in the curve of her neck and tucked a blanket from the warming cupboard around her shoulders.

And yet I wonder - What is the experience of recognizing an Other?

From this first moment of our encounter there was something about her person that came out to me, some recognition, some mutually though silently acknowledged kinship.

What permits us this "recognition"? How do we "know again; perceive someone to be a person previously known"? The dictionary goes on to elaborate:

> To avow knowledge of; to admit with a formal acknowledgement
> To acknowledge formally as by special attention
> To acknowledge with a show of approval
> To acknowledge acquaintance with
> To acknowledge by admitting to a privileged status
> To acknowledge as one entitled to be heard at the time
> To acknowledge the independence of (another)

My sense is that all of these meanings of recognition were present for us.

But, how did I know how to "be" in this precious moment? Certainly, nursing text books had not even hinted at the personal intensity of this encounter. I had watched nurses, whom I admired as role models, with dying patients but my meeting with Mary had many layers beneath the observable behaviors. Did I respond to Mary in a way that I sense I would have wanted if our positions were exchanged? I do not think this was the case, I did not have the sense of talking to the mirror.

Was I able to receive Mary directly, recognize in her a "self"? If so how can this be, is it an ability due to some shared human quality--to see or hear or touch another? Receiving means accepting, having the capacity for. How do we permit each other this entering--this encounter face to face?

Response

At 7:45 Dr. White arrived, reviewed the medical data and talked with, and briefly examined Mary. He subtly determined that she understood her terminal condition and asked if she had any questions or whether she wanted to talk with him of any concerns. She thanked him but declined further discussion with him. Back at the nurses' desk he and I reordered the formal medical care priorities. The actual treatment did not change dramatically, we would continue the drugs to support the failing heart. This would likely assure "a more comfortable death" while, in Mary's case *not significantly prolonging nor changing the inevitable outcome. Dr. White went to the waiting room to talk with Mary's husband in order to explain the situation and elicit his support for our proposed plan of care. He sought his concurrence that it would not be in Mary's best interest to attempt to prolong her struggle with more "heroic measures" of advanced cardiac life support.*

Mary was resting quietly. I was tending to intravenous lines, measuring urinary output, gathering and recording numbers, documenting the undeniably deteriorating state of Mary's clinical condition.

Al Webster appeared in the doorway of Mary's room. I went to him and we stepped out to a quiet nook nearby. After introducing myself, I started, "Mary is very sick, has Dr. White spoken with you?" He whispered hoarsely "He said she will not last the day...(brief silence)...I want her to be kept as comfortable as possible"...his voice trailing off till inaudible. I touched his hand "I will...and I am glad that I am able to be with you both today." After another of the silences that seemed to punctuate the poignant phrases of this day, he asks "Does she know?" I nod. He answers in a nod of relief. As I accompany Al back to Mary's bedside he walks to the foot of her bed, staring at her sleeping body in stunned helplessness.

I pulled a second chair up to the side of the bed and indicated that he should sit with us. He, Mary and I formed a triangle for much of that day.

After a while Al seemed eager to tell me of the experiences of his 30 years of marriage to Mary. He talked of her; her accomplishments, her humor, her personality, the way she overcame difficulties. It was clear that he was proud of her, he loved her and at least for now could not imagine life without her.

He could not bear to look at her for very long. He confided that he did not want to touch her "the way she is now, I want to remember her as the warm and vibrant woman she has been." Only once did he reach out to brush back her hair with his finger tips. She opened her eyes and smiled *at him tenderly. He talked to her only when 'announcing' his comings and goings from her room.*

She did not reach out in hand nor word, but I knew she was aware of his presence. I sense she understood his pain and respected his needs probably as she had done for thirty years. However I noted she rested more peacefully in his presence.

I wonder - What is "responding" to an Other?

A part of me finds my own words incredulous, "glad to be here with you both!" How did I get assigned this part in life's play? Feeling like I'm blundering entrances and exits, ad-libbing the script--or am I really? Maybe I am just remembering the lines as they come from my lips.

To respond is to answer, to reciprocate in a reply. What responses are possible? I felt myself to be ad-libbing the way I was present. What prompted my desire to insert those particular lines in that special experience?

Al was initially stunned into a voiceless helplessness. He felt numbed, confounded by overpowering emotion. However, he regained his speech to talk of life shared with Mary, to speak of a warm and vibrant woman. He remembered, put together again, what was essential in their presence to each other. In their mutual love, each for the other, he looked back to be mindful again of respect and honor. Was this quality of presence made possible by a regard for their connection yet a consideration of their separateness?

Embodied Caring

Mary slept most of the time. I ostensibly kept busy minding the numbers that the machines generated, recording them on the chart, titrating the medications to ease the work on her failing heart and help her body maintain balance and dignity in its final hours. As I looked around the room I rejoiced that the nurses who helped design this unit were able to influence the architectural planners. This high tech setting was humanized with soft earth tones, indirect lighting and large windows. The rounded corners of the cabinetry and woodgrain arborite offered an *hospitable feeling. There was a sense of openness that balanced the needs of privacy and accessibility. The equipment was tucked away as much as possible behind the patient. It is hard to see the person in the bed if they are lost in a forest of IV poles and behind barricades of monitors.*

Whenever Al went out of the room for a 'break', I took the opportunity to talk with Mary. She asked for both technical information (for the scientific part of her nurse-educator self) and also expressed her more personal feelings and thoughts. As we talked, I often used this time to bathe the cold clammy sweat of cardiogenic shock from her skin, to rub her back, and help her into more comfortable positions. During these times we developed a quiet, shared intimacy. Perhaps the crisis permitted us this comfortable ease in each other's company that is usually reserved for close life long friends.

We talked of our professional lives. There was delight in her eyes and a tone of awe in her voice when she spoke of "her" former students. As I responded to her speech I was amazed to find a renewed clarity in my own vision and a fresh articulation of my aspirations. This shared ministering was indeed reciprocal.

About 11 a.m. I was called to the phone. The woman on the line identified herself as Linda Bradley, a close friend of Mary's. She inquired about Mary's condition, asked if Al was there, and would it be okay if she and another mutual friend, Susan, came to visit. I gave her the information, and let her speak with Al on the phone. Linda and Susan arrived about a half hour later.

In the meantime Al had explained that they were "her" friends but soon after they arrived it was clear to me that they came not only to be with Mary, but also to be an extended family for Al. They were very practical in their care for Al. They took him away for a while with an offering of lunch. Later that afternoon they drove him to his home to freshen up and returned with him when he was ready. They offered to make calls to relatives and friends.

In contrast, they understood the essential element of interaction with Mary was just to be with her. They sat with her, held her hand, talked sometimes. Tears frequently flowed unabashedly down Susan's cheeks; Mary would sometimes join her. Often these tender moments would be highlighted by soft, shared laughter in response to a quip from Mary. Al's reference to her humor was given evidence. Even in her dream-like consciousness, due to her deteriorating cardiac function and the medications, Mary was indeed vibrant.

I wonder - How is caring embodied?

We formed a fellowship of caring; Mary, Al, Susan, Linda and myself. That day we five shared in this dance, this engagement.

"Care" originally meant to "mourn over a bed of trouble or sickness." As I look back to that day I see that our fellowship journeyed through the lived-meanings of "care" in a way that paralleled the lexical definitions:

- to be troubled, uneasy or anxious...
- to take thought for, provide for and look after...
- to have a regard or liking for, as worthwhile...
- to have a fondness or attachment.

Is the journey from "mourning" to "attachment" merely capricious etymology? My sense is that they are very interrelated, perhaps not in a linear way but in a spiral-twisting back to circle again and again.

This mourning/attachment was corporally incarnate. We danced the patterned movements of this care in flesh and blood upon the earth. The lived-space for this dance hospitably received us and generously opened a place for our humanness. Skin, eye and voice of sensual bodies engaged in the comfortable ease of shared intimacy. Tears and laughter were evidence of embodied spirits. This shared ministering took multiform concrete expressions.

The Space Between

By 6 p.m., Mary's condition worsened. She needed increasing amounts of morphine and vasoactive drugs to keep her lungs clear and her breathing *less labored. She only opened her eyes occasionally as we came and went from the room.*

Physiologically there was no reason for Mary to still be alive. Her heart was barely circulating blood to the rest of her body. Her organs were 'shutting down' in response to this deprivation. Her heart beat became more irregular with intermittent periods of life threatening dysrhythmias. It seemed a sadistic teasing of death to threaten, then spontaneously resolve back to normal. But later I wondered if maybe it was Mary's body flirting with death, letting death know she would come when she was ready.

I was torn. I wanted this difficult transition to be over for all of us. Part of my role in critical care nursing was traditionally seen as guardian of the body's life. Although I knew what we were doing--helping Mary, by our presence, with her death--there seemed in me a great deal of unresolved tension.

It was now about 6:30. By administering morphine and titrating her cardiac drugs, I had tried to assure Mary's comfort. Al, Linda and Susan were sitting at her side talking together quietly. One of my nurse colleagues insisted that she take over the vigil while I slipped into the coffee room on the unit for a supper break. I had felt at ease when I had left Mary's care to another nurse at lunch time while I went to the hospital cafeteria. At that time I had brought back a sandwich to put in the unit fridge for my supper, guided by some unspoken sense.

Now, robot-like I unpacked my sandwich. As I heard the monitor alarms, my own heart in my throat, I understood their proclamation. A few seconds later as I stepped into Mary's room I looked into the eyes of those around her bed. They were caught in the momentary shock and panic that comes when one realizes that the expected, even lovingly awaited moment, had surprisingly come.

Again I felt pressed into the ritual of my expected role. In a single flow of motion I silenced the monitor bell, checked Mary's pulse, and laid my stethoscope on her chest anticipating the inevitable silence.

I wonder - How do we understand a living/dying in the space between a technological world and a world of being?

Were the liturgical procedures of the intensive care unit all empty routine? Maybe, but possibly this last rite gave us all a little more time, a verification that, no, we were not imagining Mary's death. It offered the opportunity for a comfort in the coincidence of such powerful human emotions and the stark facts from the science of physiology. How did I play this part of my role, this part of my being? It seems I was informed and comforted by some unarticulated inner knowing, some recognition of Mary, her husband and friends into a way of being, of responding to life and death on this particular Sunday afternoon.

While we are embedded in this idiosyncratic, ambiguous, human condition, we also stand in the midst of a logical, orderly, predictable, technological world. Does this require us to be torn by schizophrenia or is it possibly a call to inaugurate a new polytheism? Is this an opportunity for a comfort, to find strength in the coming together of these pluralistic realities? Certainly, I cannot imagine life in the intensive care unit that would not venerate these diverse perspectives.

In Celebration

Al needed to leave the room immediately, so he and I went to an adjacent quiet place. Linda and Susan soon joined us. There were no dry eyes in the room. We talked of Mary. They spoke of her life, of her person, as she had lived her life. I shared my knowing of Mary when we talked of this day. In spite of the tears, or possibly enabled by the tears, our being together felt in some way whole and in celebration of Mary, in celebration of our own lives.

So - How do we celebrate life/death?

What did we proclaim with our public and appropriate rites? How did we honor--observe our understanding of life and death? Did our being together in some way make us whole? What allowed us to feel complete, sound, healed?

I have cared for many patients before Mary and many since then. Although there was a special uniqueness on that particular day, I have witnessed this phenomenon of recognition in many of my encounters with others. Nor do I wish to imply that it is limited to, or even predominantly found, in nurse-patient relationships. I believe it to be a human experience.

Our very language alludes to its presence when we speak of this recognition, this connection in our everyday lives. For instance we may say:

- When I saw the grieving family my heart went out to them.
- As I travelled through the slums of the city my eyes took in the suffering children.
- I was touched by his story.
- It felt satisfying to be really heard.

I have heard this relatedness named "caring" or "empathy" as though by giving it a label we have encompassed it. For me it is an undeniable quality of our human existence that begs for a better understanding.

CHAPTER II

THE CONTEXT OF THE QUESTION

My experience with Mary and the subsequent writing of and reflection on this story was clearly a turning point in my journey. The quest to more clearly understand myself in relationship to others in my professional practice would now pursue a more conscious, purposeful pathway. That pilgramage has led directly to this study.

In brief, I wish to focus my question on how the critical care nurse perceives and responds to her relationships with others in her professional life. I want to understand what this person is saying about relationality from her particular subject position(s). How does she 'imagine' herself, create herself in these interactions?

However, I begin with more of an introduction of my self because the history of this self is the matrix in which my question is intrinsically embedded. These experiences not only permit me to ask these questions but compel me, through the grounding of my orientation, to wonder about life in this way.

Genesis of Wondering/Wandering

The recurrent image of this self as a wonderer/wanderer is firmly rooted in childhood. I was a female child of working class, Catholic, second generation German immigrant parents. As I grew up, I watched them struggle to integrate traditional values with the American promise of upward mobility. My two siblings were considerably older than I. My family lived in a rural area adjacent to a mid-sized U.S. midwestern city. I spent much of my preschool years exploring nearby fields and creeks in the company of my dog. In retrospect, I believe that the context of these experiences in nature had a profound influence on my sensibilities and on the personal epistemology I would embrace.

Annie Dillard (1982) describes the sensibility to this kind of knowing in the story of her encounter with a weasel.

> A yellow bird appeared to my right and flew behind me. It caught my eyes; I swivelled around - and the next instant, inexplicably, I was looking down at a weasel, who was looking up at me.
>
> I was stunned into stillness twisted backward on the tree trunk. Our eyes locked, and someone threw away the key.
>
> Our look was as if two lovers, or deadly enemies, met unexpectedly on an overgrown path when each had been thinking of something else: a clearing blow to the gut. It was also a bright blow to the brain, or a sudden beating of brains, with all the charge and intimate grate of rubbed balloons (pp. 13, 14).

Similar experiences in my childhood called me to live in a world of complexity, ambiguity and to cherish the enchantment of the moment.

In contrast, both my eight years in a small rural parochial grade school and four years in a Catholic girls' academy in the city provided a solid base in academic rigor and moral principles. During this period, reflection was encouraged but only through disciplined principled thought. On my graduation from this academy in 1962 an award for "citizenship and service" bespoke the fact that I had internalized these values very well. The ambience and support structures of same-sex schooling shaped and reinforced a sensibility of my place in this world that would be consistent with my future choices. I never doubted that as a woman I was capable of accomplishing whatever I chose in this world. All my role models reinforced this perception.

During the 1960s, my life paralleled that of many of my contemporaries in the U.S. during that decade. I rejected a University scholarship in favor of experiences in the "real world" - questioning the validity and usefulness of academic knowing. During this period everything was to be reexamined, all values and truths of the dominant culture were open to doubt and were subject to inquiry. In my wanderings I was influenced by the writings of the existentialists, especially Martin Buber. I began focusing on issues concerning the dilemmas of authenticity, integrity, and human relationship. I was active in dialogue and deed in issues surrounding the second Vatican Council, the U.S. Government poverty programs and the anti-Vietnam War movement. For me, this period was a time for introspection, critical idealism and personal activism.

By the late 60s, compelled by "the practical", I sought to find a niche in society. Nursing seemed to offer a means to find a home in the world. I sensed a diversity in this profession that could encompass the breadth of my personal ways of viewing the world and that this career would provide a context in which I could continue my exploration. Chance provided the opportunity to specialize in cardiac intensive care nursing. I have been able to use my experience in this field for twenty-two years to exercise my knowing of the world in scientific, humanistic, rational, intuitive, empirical and spiritual ways. I have been engaged in this area of nursing as a bedside practitioner, educator and administrator. I know intensive care nursing with the intimacy of an expert yet I continue to stand in wonder at the intricacy, uncertainty and apparent paradox that surrounds me in this setting.

I am still caught off guard and at a loss for words when someone asks "What is it to be a critical care nurse?" "What does it take to become a good one?" I have witnessed countless powerful interactions and poignant relationships with patients and their families. I can also attest to complex dynamics between and among the 'caregivers'; some to be regarded in honor, others in horror. Relatively few of these encounters are spoken of except in a very superficial way.

As an educator for this specialty area, I often pondered what the curriculum should include besides the technical skills and vigilant assessment. Can one teach caring, let alone plan for its implementation or measure it as a competency?

As an administrator of a critical care unit, I considered how I could support "positive" relationships. Is there a connection between patient care and nurse care? We had systems of patient acuity, work load indexes, and quality monitoring. How were all these numbers juxtaposed with the sentiments enclosed in the hundred of thank you cards from expatients and families and with the low rates of staff turnover? Were they speaking of the same realities?

The main challenge for me in this journey toward a better understanding of what is going on in the relationships in this setting is the difficulty of language, the failure of words. My hope is that through this study I might provide space for the voices of those embedded in this world to recall a fuller meaning and find a clearer articulation.

This biography (as well as the scholarly influences that I will address in the next chapter) provides much of the perspective from which I am able to reflect upon the lived world of the nurse working in an intensive care unit. Let me sketch a few ways in which I perceive this world to be complex, ambiguous and often paradoxical.

Significance of the Question

Patterns of nursing thought and practice can be diverse and eclectic. At times this profusion of perspectives is deplored by nurse theorists, educators and practitioners because it defies a concise unified position for all nurses. In spite of this diversity there are interpretive frameworks that do dominate many specific areas of nursing. Academically oriented nurses have been traditionally in the grip of scientific positivism. Nurses working in hospitals are surrounded by the pervasive 'illness-cure' paradigm of the medical model and pressed into the service of technological ends. Overarching these perspectives is a belief by the public and by nurses themselves that caring for others is foundational to the profession of nursing.

Let me be more explicit about these diverse perspectives with the example of intensive care nurses. Ostensibly the responsibilities of these nurses are threefold. First, to provide care for the critically ill and their families; to be a helpmate in the service of suffering humankind. Second, they are also expected to assist in the application of the "cutting edge" of medical science and technological advances. Third, they are accountable to the political hegemonic structures of modern western medicine and of the big business of health care provision. To serve the voracious demands of any one of these three areas is often overwhelming; to serve them simultaneously is frequently impossible.

Who are these nurses? Surely they must stand on firm ground to juggle so many complex responses! How might their 'typical' psycho-social profile be described? How do they imagine themselves? How might they form their diverse subjectivities? The majority come from middle class backgrounds. Many of them have family responsibilities in addition to their nursing careers. They are accustomed to being marginalized as women and as nurses. And yet they find themselves in the very center of all that transpires in the intensive care setting.

Can we explain these apparent contradictions by naming them surrogate mothers?, wise nurturers?, or the emotional glue which holds this health care team together? Even though they may be expected to be empathetic "angels of mercy," they are constantly required by the profession and the hospital to be technically efficient, clinically effective and to display appropriate detachment. In short, nurses must embody diverse world views; the impartial clinical approach of the scientist with the involved caring approach of the humanist; the marginalized position of the servant with the privileged status of an ambassador; the role of advocate representing the patient, with the role of the purveyor doling out the services in the name of the establishment.

Over the years that I have been involved in this setting, I have the strong sense that this exquisite balancing venture is not talked about concretely in nursing education nor addressed explicitly by most nursing administrators. Yet these tensions are in the very core of our lived experience.

As I try to make sense of this world, I keep coming back to questions of relationship. I am drawn to the exploration of how these nurses see themselves in relationship with others in their professional lives. How do they perceive themselves, and interactions with others in this setting? How do they know and respond to the others in this world? The others in this setting include: patients and their families, nurse colleagues, physicians, various health care workers, and administrative personnel.

Nursing literature has been endowed with a multitude of writings concerning professional, therapeutic and/or caring relationships in nursing. Some examples of nurses who have written on relationships as foundational in nursing are Watson (1979), Carper (1986), Gadow (1987), Benner and Wrubel (1989), Fry (1989), Crowley (1989), and Hedin (1989). A number of nurses are asking that we critically examine the philosophical and androcentric underpinnings of our theory and practice, such as scientific rationalism and gender constructions. Examples of these include Carper (1975), Parse (1981), Thompson (1985), Watson (1985), Chinn (1987), Leininger (1988), Holmes (1990).

In this inquiry, the nurses have been asked to set aside merely "received knowledge" (Belenky et al., 1986) and as much as possible to go beyond the taken for granted to wonder/wander in their own experiences of relationship with others in their professional lives.

I have been joined in this research by a number of critical care nurses. We attempt to bring to consciousness, articulate in words, find a voice for narratives that might help us all to be more clearly aware. These understandings may enable us to choose in a more reflective way how we live our praxis in our professional lives.

The story *Re/membering with Mary* raises the question - who is this critical care nurse, how did she relate to others "on that particular Sunday afternoon"? This is a question of identity or perhaps more accurately a question about how do we imag(in)e ourselves? How is our subjectivity formed/informed? This has profound implications for me as a nurse educator. These questions will be explored in Chapter Five.

Theoretical Frameworks that Shape the Question

I am drawn to the exploration of how intensive care nurses see themselves in relationship with others in their professional lives. How do they perceive self and others in the interactions of this setting? How do they know and respond to the others in this world? The others in this setting include: patients and their families, nurse colleagues, physicians, various health care workers, and administrative personnel.

In brief, I wish to focus my question on how the critical care nurse understands and responds to her relationships with others in her professional life. I want to understand what this person is saying about relationality from her particular subject position(s).

I have received inspiration in this inquiry from three forms of scholarship: postmodernism, hermeneutics and feminism. They have breathed a particular quality of life into this project by offering ways of approaching and making sense of the question of relationship in nursing practice. I will briefly describe how each one has informed this research and influenced the methodological approach. The following pages will attempt to demonstrate how these three very distinct forms of scholarship have been woven together in this particular inquiry. Many of the writers quoted here would not necessarily agree with the general tenets of the other orientations. Some would perceive disjuncture; some would find the others' views an anathema. I do not deny that there are tensions, nor do I attempt to fit them neatly together.

Although there are differences there are also points of conjunction among these three forms of scholarship. These are:

1. Each calls into question taken-for-granted universalized understandings.
2. Each values the analysis of the discourse of everyday life.
3. Each encourages a close examination of the uses and abuses of language.
4. Each espouses support for the speaking subject as a subject in progress.

Each of these addresses the importance of interpretive listening and interpretation. As Mary Daly writes:

> In the beginning was not the word. In the beginning is the hearing. Spinsters spin deeper into the listening deep. We can open only what we hear. We can weave and unweave, knot and unknot, only because we hear, what we hear as well as we hear.
>
> (Mary Daly, 1978, p. 424)

What follows is an overview of each of these forms of scholarship focusing on how each applies to this research.

Influences of postmodern thought

The postmodernist critique of modernity is wide ranging. I incorporate several aspects of that critique which I consider central to this inquiry. As Rosenau (1992) points out, many of these ideas are not original to postmodernism. However, postmodernist thought has employed them in a particularly potent manner. Postmodernism offers a

> substantive re-definition and innovation ... outside the modern paradigm, [in order] not to judge modernity by its own criteria but rather to contemplate and deconstruct it.
>
> (Rosenau, 1992, p. 5)

There are many forms of postmodernism but the form termed "affirmative postmodernism" by Rosenau has influenced my thinking most closely. Affirmative postmodernism seeks to reclaim "the traditional, the sacred, the particular and the emotional" (Rosenau, 1992, p. 6). Such forms of knowledge have been set aside by modernity and marginalized outside of the borderlands of universalized regimes of truth. Not only do the "affirmatives" seek such reclamation in the broader sense of rewriting and reworking the past but they respect one's own past, the rememberings of others' pasts, histories and meanings. This sympathy informs my study; indeed, a respect for others lived-experience might be said to be the "mortar" that binds together the experiences it describes.

In regard to the calling into question taken for granted universalized understandings, many "affirmatives" redefine truth. As Rosenau writes: [affirmative postmodernists]

> accept the possibility of specific local, personal and community forms of truth.... [They] understand truth's dependence on language to be a serious restriction.... [They] argue that a community of knowledge may establish a consensus of language and values, making it possible to communicate certain truths that, though they are not universal, hold for that community at a specific place and time.
>
> (Rosenau, 1992, pp. 80-81)

We need to be cautious when examining the claim that all criteria demarcating truth and falsity are internal to the many strands of modernity and represent "regimes of power". This could easily lead to complete relativism and the entrenchment of solipsism. Rather, postmodern thought may be heard as a call for the careful examination of the "taken-for-granted" in order to dethrone the quest for the universal. Reality itself may be relentlessly plural and heterogeneous but the "view from everywhere" may be as problematic as "a God's eye view". It seems that human understanding and response must be situated in a historical, cultural, gendered, embodied context (Benhabib, 1987; Bordo, 1990; Nicholson, 1990). Can we hope for more? I see postmodernism as a call to "thought spawned by the encounter, a thought nourished by divergence, disjunction, yet also by affirmation" (Olkowski-Laetz, 1989, p. 185). It also may be a call to the possibility of a different ordering of knowledge, experience and desire. Renee Baert talks about the potential difficulty presented by this possible reordering when she writes about "enchantment."

> Enchantment is to the academy as myth is to *logos*, shamanism to medicine, passion to power, knowledge to information, emotion to reason. All represent an Other in relation to the Law (Baert, 1990, p. 6).

The second way that postmodern thought informs this work is that postmodernist discourse engages in a form of "*le quotidien*", or daily life analysis. Since nursing is nursing *practice* it is embedded in "le quotidien." In this study the interrogation of how we as critical care nurses stand in our professional world does not expect a finite nor an homogeneous reply. There is a belief in the value of a personal individual nongeneralized form of knowledge which directs this study and which best reflects my ongoing epistemological orientation.

Lyotard (1984) suggests that a narrative tradition defines a "threefold competence - 'know-how,' 'knowing how to speak,' and 'knowing how to hear' - through which the community's relationship to itself and its environment is played out" (p. 21). This study illustrates these criteria of knowledge in the narrative tradition.

Although John Caputo (1989) supports the idea that the meaning of Being ends up as the multiplicity of meanings, the manifold unfolding of the many senses of Being, he believes that we can indeed "proceed after the breakdown of all hermeneutic privilege, after the loss of the master name."

> I would defend a notion of action that arises not from the security of metaphysical foundations but from a profound sense of the insecurity to which we are exposed. We act not on the basis of unshakeable grounds but in order to do what we can, taking what actions as seem wise, and not without misgivings. We act, but we understand that we are not situated safely above the flux and that we do not have a view of the whole (p. 59).

This kind of understanding suggests that we might speak with tentativeness, yet with an assurance that we can take what action or speak in a voice "as seems wise." I would suggest that indeed this multiplicity of meanings is in fact what allows us to hope for greater wisdom. Caputo (1988) describes the process of this kind of experience

> is to a great extent a matter of knowing how to move around within a textual system which both enables that experience to happen and disables it from trying to detach itself from that system, as if it were some atomic bit of data (p. 66).

The linkage between postmodernism and hermeneutics continues with a third conjunction, language. This concerns the ethics of language which is central to the narration of lived experience. The affirmatives believe that hermeneutics is the approach that best probes the "silences", attempts to uncover and recover hidden meanings. Hermeneutists see knowledge as multi-layered and significant in the various understandings of what consists of language, its uses and abuses.

Relevant to the fourth conjunction, Julia Kristiva (1986) refers to the postmodern subject as "a work in progress," a "speaking subject, both imagination and imaginary". A work in progress has more to do with "indeterminacy rather than determinism, diversity rather than unity, difference rather than synthesis, [and] complexity rather than simplification" (Rosenau, 1992, p. 8).

The affirmative postmodernists assist in a further understanding of the importance of "differences" to this study. The affirmatives endorse a methodology that depends on emotion, intuition, imagination and normative processes (Rosenau, 1992, Chapter 7). In doing so, they propose that "subjects" - in this instance the participant nurses engaged in dialogic investigation - be seen as focused in the daily life they experience at the margins of medicalized scientific (totalizing) systems. This view shows a respect for subjects rather than seeing them as puppet-like objects moving within deterministic processes of totalizing systems.

> But neither do they [affirmatives] shy away from normative stands. Formulating value positions that are broad and inclusive is a delicate task; it requires considerable diplomacy and an exchange of views that does not attribute dogmatic authority to anyone.
>
> (Rosenau, 1992, p. 146)

It is the emphasis on subject position that separates the affirmative postmodernists from their "skeptical" counterparts. The latter's view of the world tends towards nihilistic conclusions - meaninglessness, social malaise, pervasive alienation and a cynicism about moral parameters. "If, as the skeptics claim, there is no truth, then all that is left is play, the play of words and meanings" (Rosenau, 1992, p. 15). It must be apparent to the readers of this study, and is evident in my brief autobiography that this is not how I nor the other participants position ourselves in the postmodern world. With other 'affirmatives' I am content with a personal, nondogmatic and nonideological view. I wish to affirm in my life and scholarship a "visionary and celebrating" rather than an "apocalyptic and desperate" postmodernism (Rosenau, 1992, p. 16, note #11).

Influences from hermeneutics

Hermeneutics, as the art and science of interpretation, best describes the research orientation of this study. The realm of human action receives attention not in order to explain, predict or control an objective world but in order to understand the personal meanings that the participants give to their experiences.

In hermeneutics the conjunction taken for granted is called into question through the analysis of the discourses of everyday life. In this process of this study there was an attempt to take a pre-theoretical position in order to hear the voices of the nurses as they described and discussed their way of being in the world. This attentive openness to possible interpretations did not deny nor ignore that the speakers and listeners were situated within a general tradition. This tradition makes possible but also limits the scope and depth of any understanding (Gadamer, 1975). The task of interpretation is an understanding of being-in-the-world. The meanings unfold through the dialogue which enables interpretation as a way of knowing. John Caputo (1987, 1989) proposes a radical hermeneutics which attempts to restore life to its original difficulty by suggesting that the search for unitary explanations of being is impossible. According to Caputo, radical hermeneutics culminates in the dissemination of meanings, the pluralizing of the senses of meaning. I wish to uncover through dialogue, the interpretations of these intensive care nurses of their being in the world, how they know and understand the multiple unfolding of their lives.

The examination of language for the purpose of understanding is at the very core of hermeneutics. The hermeneutics I engage in throughout the study and with the other participants is that of listening and hearing in order to interpret the lives of others even as they are given leeway simultaneously to interpret their own lives. As Levin (1989) reminds us, we must not reject before we hear. We must train ourselves in dialogic insight, becoming cognizant of those things that are not obvious, or those experiences for which the subject has difficulty in finding adequate words. We must, however, not merely be receptive to the other but we must be vigilant not to privilege one discourse over another. The hermeneutic approach to my work introduces all participants to what is identified by Derrida as the "ethics of the ear" or the ethics of "caring" (Michelfeder, 1989).

This research requires the construction of the subject position(s) of the nurses whose stories were approached through hermeneutic processes. The participants were committed to "talking with" the other(s), "listening to" their stories and dealing with many meanings and interpretations. The dialogues between the nurses during this study celebrate our differences in a way that we explore the possibilities of our ways of being in the world. This perspective frees us to ask our own questions and to pursue paths of thought that arise out of our experiences in our practice of nursing. We are subjects in progress.

Influences of feminist thought

If hermeneutics and postmodernism coincide in areas of questioning taken for granted understandings, a valuing of lived experience, an exploration of "voice" manifest in language and a concern for subject position; it is also in these aspects that feminist scholarship assists in situating this study.

Most nurses are women. This fact is not coincidental nor without implication. Current feminist scholarship is helpful in questioning the significance of gender in this context. I take seriously the warning of many feminist writers that any endeavor to describe *essential* women's experiences is fraught with difficulties (Grimshaw, 1986; Spelman, 1988). However, it seems apparent that the "situatedness" of their gendered identity in our society will influence how these nurses see themselves and others in their professional lives (Fox-Keller, 1985; Grumet, 1988). Since women are identified with the marginalized position of difference, the personal is also political. Therefore the ground of their response forms a political context with respect to the legitimacy of conceptual, epistemological and ethical questions (Singer, 1989).

The crucial intersection in the questioning of accepted truths and feminism is most evident in the need to deconstruct the patriarchal text. That text has been handed down in phallocentric and misogynist traditions that have transmitted a privileged status to male gendered discourse even within other social categories such as race and social class. These phallocentric traditions are evident in medicine.

History supports the contention that the affairs of humankind are not value-free and objective. Herbert Butterfield, whose 1931 essay "The

Whig Interpretation of History", provoked major reinterpretation of the nature and process of historical scholarship. He commented, with tongue in cheek,

> There can be no complaint against the historian who personally and privately has his preferences and antipathies ... it is pleasant to see him give way to his prejudices [in the interest of colour and liveliness] ... provided that ... he recognizes that he is stepping into a world of partial judgements and purely personal appreciations and does not imagine he is speaking *ex cathedra* (p. 2).

Feminist history unabashedly denies that it is value free and apolitical. It replaces androcentric assumptions with the social construction of gender and power structures at the core of its inquiry (Smith-Rosenberg, 1985). The recognition of personal histories or local narratives is significant to the revision of androcentric knowledge claims. Carol Heibrun's essay "What was Penelope Unweaving?" (1990) provides an excellent articulation of why this type of storytelling is central to interpretation and empowerment.

> Penelope is faced ... with an as yet unwritten story: how a woman may manage her own destiny when she has no plot, no narrative, no tale to guide her. Imagining, inventing, she weaves and unweaves and knows ... that the time for the enacting of her new story has come.
>
> Why do I say Penelope is without a story? Because all women, having been restricted to only one plot are without a story. In literature and out, through all recorded history, women have lived by a script they did not write.... (p. 126)

Narratives are the very substance used to transform and to understand one's own life.

The use of narrative to understand women's lives is not reverting to essentialism. It is not intended to be a composite, a fusion. It is not an essential category in the sense of one of a possibly exhaustive set of a priori classes among which all things might be distributed. It is a linguistic convenience in which we may come to speak of individual subject positions which often have some similar responses to things like 'oppression'and 'gendering' etc.

The feminist writer, Audre Lorde (1984) described the power in the affirmation of differences in these words:

> Only within that interdependency of different strengths, acknowledged and equal, can the power to seek new ways of being in the world generate, as well as the courage and sustenance to act where there are no charters.
>
> Within the interdependence of mutual (non-dominant) differences lies that security which enables us to descend into the chaos of knowledge and return with true visions of our future, along with the concomitant power to effect those changes which can bring that future into being. Difference is that raw and powerful connection from which our personal power is forged (p. 111).

A high regard for language and voice have become central to feminist discourse. In my research it has been vital that the spirit of the conversations provide a milieu in which these women's voices may speak authentically and receive responsible hearing.

Carol Gilligan (1982) called attention the interaction of experience and thought for women suggesting the possibility of "different voices and the dialogues to which they give rise in the way we listen to ourselves and to others, in the stories we tell about our lives" (p. 2). This inquiry process takes into account the possibility of this other voice. However, in this research that "voice" is not to be taken for granted but given a keen hearing as it emerges.

In their intensive interviews with 135 women, Belenky et al. (1986) found a "tendency for women to ground their epistemological premises in metaphors suggesting speaking and listening."

> What we had not anticipated was that "voice" was more than an academic shorthand for a person's point of view. We found that women repeatedly used the metaphor of voice to depict their intellectual and ethical development; and that the development of a sense of voice, mind and self were intricately intertwined (p. 8).

Feminist discourse supports women as subjects in progress. It explores how we might construct our own script of our lives in as much as possible free from a plot received from a patriarchal milieu.

There is a difference between "fact" and "figuration" in matters pertaining to women as subject(s), such as experiences spoken of by victims of patriarchal oppression (Flax, 1990, p. 225). In these matters postmodern feminists (and one might argue this is tautological that all feminists are postmodern in their refutations of modernity's construction of gender) are grappling with issues of objective reality - oppression and the need for a practical politics with a privileged discourse - the imperative to transcend master narratives.

> [As feminists] we have developed the power and resources to separate our agendas from [our fathers]. We may already be in a better position than we realize, a position from which we are empowered to ask our own questions, rather than continuing to try to respond to those we have been left with. Such questions are vital not because they liberate us from the effects of this past, but because the answers we produce together will help determine our future.
>
> (Singer, 1989, p. 116)

This study is based on the affirmation that the subject-position (nurses voices) is critical to understanding, therefore interpreting their images of themselves, their "self actualization", their "structuration" (Giddens, 1991) within an institutionalized and logocentric text - the hospital setting. For Giddens

> the 'politics of self-actualization' concerns the development of a fulfilling and satisfying life for all, in the context of a world in which the local and the global are continuously bound up with one another. Questions such as the proper relation of human beings to nature, the legacy of present acts for future generations, ... all form part of life politics (p. 212).

Thus I am interested in notions of "deepening" the subject and reconciling the subject as agent, in the face of the constituting power of the modern medical system. Such decentering affirms that self actualization is possible and that these women as postmodern subjects are in touch with the impulse to self actualise even within rigid institutional structures. The subject can engage actively in reflective processes; the subject has a self identity and is not only an institutional end product (Rosenau, 1991, p. 59).

The Process of Inquiry

Influenced by hermeneutic, feminist and postmodern views, it is important to establish harmony between the intent of the inquiry and the method of inquiry. The primary inquiry is announced by the basic question "What are the personal meanings that nurses give to their relationships within the context of the intensive care unit?" The ontological underpinnings discussed in the previous sections of how I understand the question must be consonant with the way of proceeding in the exploration of possible responses to that particular question.

I will first describe the specific itinerary of the research journey. Second, I will delineate some implications related to language and ethics. Third, I will describe some of the actual experiences of the group's deliberations and fourth, introduce the participants.

Conduct of the research - the pilot study

In the summer of 1991 during the proposal stage of this dissertation, the advisory committee felt it would be beneficial for me to engage in a pilot study. The purpose of this project would be to become clearer on what kind of research process would establish a harmony between my research intents and methodology. There was also some concern whether nurses would be willing and able to participate to the extent required in this process.

I invited a small group of nurses to join me in a series of conversations to explore the experiences of relationships in their professional practice. Four nurses accepted the invitation and met with me in a group on three occasions during the early summer for a total of about seven hours.

This inquiry was originally framed within the context of intensive care nursing because this was the place in which I was situated when I began to wonder about the experience of relationship in our professional lives. I have since come to believe the themes which emerge from this study are not unique to critical care nursing.

Since the pilot study was undertaken in order to become clearer on the methodology, it was not a concern that the four nurses represented a variety of settings as they joined in a dialogue of their experiences of relationship. These stories and understandings were very in tune with those of the two groups of critical care nurses I met with subsequently. I have included one example from the pilot group to show how these themes likely cut across many areas of practice.

This pilot study not only demonstrated that nurses were eager and very comfortable with participating in hermeneutic dialogue but one of the valuable insights for me relates to the documentation of our time together. The richness of the communication led me to choose to videotape all later sessions in this research because audio tape and its subsequent transcriptions were so impoverished. I made this decision because I felt that so much "life" is lost in the reduction of these complex and multidimensional interactions to a linear, flat transcribed page.

The following conversation from the pilot group is provided as an example of a process that recurred frequently in our times together. The nurses start with a query of some experience that perplexes them. They then proceed to a series of clarifying dialogues and stories followed by more dialogues and stories until they became clearer on the issue.

Chris: *It's one of those situations that I will always remember because I felt like I was the tool. Maybe you can help me describe this. I felt like just being Chris, just me, in that chair, at that particular moment, and that was helpful for that woman. I don't really know; I don't know the parts of that.*

Sandy: *You said something that makes me want to check it out. "You just being Chris." Is that different from you being Chris the professional? Because that is one of the things that I have found when I'm dealing with clients. Sometimes I am Sandy, case manager specialist and sometimes I am just Sandy. The times when I am just Sandy is when I am connecting and those are clients I work really well with. The ones where I was the other, I wasn't. I believe that, anyway.*

Chris: *Like shedding your persona.*

Sandy: *Is that what it was like for you?*

Chris: *I've never thought of it that way, but as I heard myself say those words just now, I realized that, that was my description to myself. Just shortly after it happened, I said it was 'just Chris being Chris'. Like that is how I described it. So maybe that is what it is!*

Sandy: *That is interesting that you described it that way. I didn't know other people felt that way.*

Chris: *What do you think about that, do you think that...*

Sandy: *I would like to be just me. Because there are things about that persona that I have to take on and it's a professional persona that I didn't like.*

Chris: *It was looking at people and looking at their cases and making judgements according to a book and people don't fit.*

Ann: *Rarely do they fit!*

Chris: *Do you think Ann, that we shed sometimes, some of the things that we put on?*

Ann: *Yes, I do.*

Sandy: *Maybe we put it on sometimes. Well, you said that.*

Chris: *I know that is true for me, when I wear my blue jeans I'm one person.*

Sandy: *And you said when you wear your panty hose...*

Ann: *A 'panty hose persona'!...*

Chris: *It's true though, there are certain ways that you behave!*

Ann: *What I also hear is that when people come into your office you can be dressed the same way and still connect differently. There is also something else?*

Shauna: *Are we saying here then, that if we are closing off then we are putting on a role?*

Ann: *Well, I don't know.*

Sandy: *I don't think so. I don't think that I have closed off. Often times when I had my professional persona on and I was willing to do whatever it was I could do. I just knew that I wouldn't say to the person, "You know what, if I were you in that situation - this is what I do." Rules aside this is how I would get around it. Because there is always a way. That is what I have found. There is always a way to get around it.*

Around the rules. Around the rules that are supposed to help people. But, when I have on my professional persona I wouldn't suggest anything quite radical.

Shauna: *Maybe it's just a judgement call. And we put our title on and take it off depending on how we feel we are going to help this person or how this person is best helped in a therapeutic way.*

Sandy: *But isn't this almost on a continuum - I mean here's a person, here's this professional* (gestures with both hands indicating poles of a continuum). *Sometimes I can be pretty cool like "Now what is it I can help you with?" And I'm sure that the person gets the frost bite! There is only so much that I'm going to do! So that is at one end of the continuum and the other one is...*

Terri: *Have you ever given your all to someone you didn't like?*

Sandy: *Always. That's is what I meant when I said 'over compensating'. Often times I have given my all, I've done everything I can imagine although I'm not sure...*

Shauna: *I know what you mean. But it is in a frosty way?*

Terri: *Like when you are dealing with family, are you very professional even though the activities you are doing behind the scenes are over and above?*

Sandy: *I guess you are right, that is exactly what I am saying about the continuum. Even though the person is here it doesn't mean that I'm over at this end of the continuum but still usually for those people I really try "Anybody, somebody give me an answer!". I'll do anything to try to solve this problem because it's not only a problem for him now but a problem for me. (pause) Does that click for anybody?*

Chris: *I certainly understand about the continuum. I say things to my children and they say "Mother we are not your patients." So I'm at the low end of the continuum and I'm not* *being mother. So there obviously are degrees - it seems to me that there are levels here.*

Ann: *What do your children understand about "How is a mother different from a nurse?"*

Chris: *I think they are saying to me that I am talking to them differently than I normally do. If I sort of stop and think about what I said or* *how* *I said what I said, there is a part of me that "tries something out" maybe. So perhaps I'm not natural or perhaps not instinctual.*

Ann: *So they are claiming an additional closeness to you?*

Chris: *Demanding my time. Yes, what they don't want is that, you know ...*

Shauna: *That laid on role!*

Chris: *Yes. Because what I do, sometimes is that I objectify my child in that situation and sort of say well how can I be more effective here. Because just being me, with whatever normal baggage I come with, doesn't seem to be helping.*

And those are the times when I might get that kind of response. My family can see straight through me and they say, "Stop treating me like a patient!"

Ann: *Objectifying?*

Chris: *Yes.*

Ann: *Then that fits very well with Chris as the 'professional' versus meeting individuals and dealing with them as human beings. So those phrases all fit. Then maybe what we find alien about the professional role is in objectifying the patient?*

Shauna: *I was just thinking. I always seem to connect with the derelicts that come through the door. It's funny because I have been asking myself, "Why"? I work at two hospitals and I very much more enjoy the clients at one hospital that are coming to me from the inner core of the city. One fellow that*

I remember looked like he was possessed or something. His eyes almost seemed to glow and yet he had dark, dark circles under them and his hair was straggly and almost looked like the wind was blowing it, but of course he was in a building, so it wasn't! His name was Ferdinand and he was just like this! He would come wheeling his wheelchair into the room and everyone would get out of the way. He was not always cognitively with it. You never knew what he was going to do. There was avoidance by some of the staff because you never knew if he was going to smile, take your hand and kiss it or if he would hold your two hands so he could hit you with the other. But I just find that those are the kinds of people that I have more of a sense of humour about. We just kind of click and I don't know why but we can laugh together.

They just pulled him off the street and I don't know where they found him. We joked about one of our surgeons was going on holidays and needed extra cash so he would make his rounds and then call the ambulance. There was a rash of these people coming in and they were always having quite complicated surgeries, by-pass surgery and that kind of stuff.

And yes, we got along just fine. We would laugh, I mean if he would kind of lose it for awhile and throw his urinal at me or spit at me or whatever, we would laugh about it and every thing would be OK. I didn't mind having him in my patient assignment. I always did get him because no one else wanted him but it was OK.

Ann: *Did you see Ferdinand as a challenge or was it that you admired some quality in him?*

Shauna: *He was just such a character! I thought, he could tell me things that I'll never see or hear again. I guess that is what it was. He's seen things that I've never seen.*

Ann: *And did he tell you...*

Shauna: *Oh great stories!*

Chris: *And you are interested in that?*

Shauna: *Yes.*

Chris: *Others might not be.*

Shauna: *Yes. That probably could be it.*

Chris: *And do you not think people sense that we are interested in them?*

Shauna: *Yes.*

Chris: *He's probably amazed by you!*

Shauna: *He called me this little girl and asked if I'm still a nurse in training and all this kind of thing. I think a lot of it was for the shock value, to see if I would go running out of the room. And I would laugh when he told me his stories and said, "Well, then what happened?" He wanted to know that his life and what he did was OK too, and to know that I was not repulsed and avoiding him.*

Chris: *Yes.*

Shauna: *He had just great, great stories.*

Chris: *And you see Shauna doesn't make this guy an object like some of the rest of us might - we might say filthy derelict!*

Sandy:(teasing) *Well, once you've been around the block A couple of times Shauna you will...* (laughter)

Chris: *But you don't treat him like that, you say, he has some fascinating stories.*

Shauna: *Yes.*

Chris: *Maybe there is a novelist in you that is dying to get out and these characters that you meet...*

Shauna: *Yes, a paper back, a best seller!*

Chris: *So there you go, the way she sees him is different than the way the rest of us might. So maybe it is that "objectifying".*

Shauna: *Sometimes people in emergency don't have the time to spend with people to get to know their personalities. I wonder if they see that is how I can try to make it sort of happy. I mean a hospital is not a fun place for anybody. If I can try to help them or say yeah, I really am trying to accommodate what you are going through.*

I float to the overflow area at this hospital. It's kind of like a holding tank. People lay on stretchers and are waiting for beds and I mean the longer you are there the more miserable you are. I think that the only way people can stand it down there is just to talk to someone or talk about something other than their illness.

Chris: *Has that become your priority then?*

Shauna: *Yes. Trying to make it a happier place for them to be. I don't think anybody wants to be there.*

Chris: *But you see these people as fascinating stories. That just turns your whole perspective around!*

Sandy: *I was like Shauna. I would try to go and look after the kids that the other nursing staff weren't fond of. They were usually disadvantaged in some way. One child that comes to mind was really not a pretty child. I can't even remember what the genetic problem was but he had been born without eyes and he had juvenile acne at 3 months old. Oh, he was really a homely little guy. I mean he couldn't hear. Well, people told me he couldn't hear but I said uh uh! When I came into the room, Curtis and I would decide what station we were going to listen to and we listened to the radio. You know we had a great time and he laughed. He was three or four months. His parents had given him up. This child had been discharged from a hospital and no one knew there was anything wrong with him! No one knew that he didn't have one eye socket, there was no eye there and the other one was blind!*

Terri: *Didn't any one check him?*

Chris: *Good Lord!*

Sandy: *I don't know how that happened but we got him because we were doing the work up on him to find out what planet this kid came from! You just had to look at him to know there was something wrong with him. I can still see his face, and I can still remember his name and that was oh - 100 years ago. Really 10 or 12 years ago.*

Ann: *And there was a connection like with Ferdinand. I mean there was a mutual appreciation of each other.*

Sandy: *Yes.*

Terri: *An appreciation of some sort...*

Sandy: *Maybe he liked the way I mixed pablum or something!* (laughter)

Chris: *I'm sure he was glad when you went in.*

Sandy: *Yeah sure, because I touched him and we played games as much as you can play games with a kid that is blind and deaf. But yes, he was the "underdog", those are the types of kids that I like. They were fun to look after. They were more...*

Chris: *See, she was having fun at work like Shauna!*

Sandy: *I think, it is because you are getting something back and it's really uncensured.*

Shauna: *They are not being judgemental.*

Chris: *Yes of course.*

Shauna: *You know we were talking about touching, I know I'm a very touchy person. I'm always touching and yet these people, like Ferdinand, he doesn't like to be touched all that much. It was a real challenge to know when it was OK and when it wasn't OK. And so maybe that is something I got out of it too is a kind of learning for me to kind of being able to read him and know when it was OK to touch and when it wasn't. For me to learn that you can't just go around hugging everyone* *because the spirit moves you and you say, "Oh, I feel a hug coming on!"*

Chris: *Watch out, here I come!*

Shauna: *Yes. So I just found that once I connect with him the walls are down and I was myself and he could be himself. It's OK for both of you to feel that way. Yes. And it's fun.*

Sandy: *And when you think of the people you work with then it wasn't work. It was just to get the best possible deal with the best possible advantage out of the situation for 'Mary', 'Joan' or whoever it happens to be. How can I do my part so she gets the best deal out of the system?*

Ann: *Do you have fun at work?*

Chris: *I think so, when I'm connecting with those situations that I feel are energizing for me. And for me if you chopped off both of my legs I'd still get there to be able to do that kind of work. Because to me that is "making a difference". I am coming to know more and more that is important to me. And I don't think I'd describe it as being "fun" but I would say it's "happening" or that's "where it's at" for me. I'd use some slightly different terms but I think it's the same thing. That's a high for me. Sometimes you have one good day and you have ten lousy ones! You know, people that you can't help or you don't make a difference. But by being able to help that one person; that keeps you going.*

Sandy: *So what happens to these people that are in the middle? What happens to these people that we don't connect with? In nursing we talk about connecting with our clients and doing all of these things. What happens to the ones you have trouble caring for?*

Chris: *I think you have to hope that you work with a Sandy, a Shauna or a Terri.*

Sandy: *Well, my question is what would happen if Shauna wasn't working casual on that particular unit? Most of the staff had different feelings towards Ferdinand. I'm not looking for any answer but to me that's the reality.*

Shauna: *I worked down at the seniors drop in centre. The people there did not have a good rapport or kind thought about the Emergency Room because of the way that they've been treated there. They haven't got anyone on staff who clicked with them and so I saw the other side of it too.*

Sandy: *I could see that it would be really hard in Emergency - to be connecting with people who've come in...*

Shauna: *Who have come in three nights in a row and have thrown up on you, sworn at you and hit you.*

(Many voices) *And when you turn the other cheek - you run out of cheeks! You run out of uniforms! You have to dodge so many times - you just came prepared!*

These nurses suggest that putting on a *professional persona* has a lot of drawbacks. The donning of this actor's mask may make them acceptable and safe but it distances them from the other. In doing this they feel they are *trying something out* and *objectifying the patient* and I suspect they also sense a distance from themselves. When they shed that persona they can be just themselves. This permits *you to connect* with others, *the walls are down, you are you, they are them and its okay for you both to feel*. This 'work' of nursing is *where it's at* and just *fun* because this is the state in which we can hear and see the other. It *turns your whole perspective around*. You're getting and giving something that is *uncensored*. Life's joys, pains, fears and complexities are not suppressed. However in order not to *run out of cheeks* or *run out of uniforms you need to come prepared.*

Conversations from the critical care context

For the main study, I pursued this quest through dialogue with research participants who are nurses experienced in the intensive care setting. I invited them to participate in this inquiry through descriptions of their experiences and explications of the meanings of such experiences. I wished to retain the complexity in their sense making and their responses to their own stories. I welcomed the possible diversity in insights and interpretive themes. It was paramount that the nurses be able and willing to participate in the reflective dialogues of this research orientation.

I sought volunteers through hand bills distributed by friends and colleagues in places where critical care nurses might gather. I followed up on the nurses' inquiries with letters of information about the study. I then arranged a pre-study interview with each potential participant to share with them my research proposal and freely discuss any details. During the interviews I listened for a willingness to openly dialogue about their experiences. I particularly attended to their awareness and articulation of their understandings of relationship in their practice setting. Seven nurses volunteered to participate in this study. They met in two groups over a two to three month period. One group had three members. The other group had four members. There was a total of 11 meetings each lasting about 2 hours. They were encouraged to tell their own stories about the meaning of their relationships with patients, patient's families and professional colleagues. There was often the use of narrative and discussions around specific situations. Because the meetings were videotaped we could go back to review any particular conversation. I assured them that the tapes would not be used for any other purpose unless there is additional formal written consent from all of those involved. Participants were assured that: 1) they can withdraw from the study at any time, 2) discussions will be confidential, 3) personal and proper names can/will be changed in the final drafts at their discretion, and 4) up until the time of the final research draft they can edit out any personal information they choose not to share.

The intent of the methodology of this inquiry is to maintain the sense making, the interpretation within the context of our speaking so that the participants may work with and clarify their own signification. The videotapes were available to remind us of what we had said, and were reviewed by some members on several occasions. It also served as a record of our journey together so that in the final phase of writing the thesis, the dialogue can be described as faithfully as possible.

In this study the process of examining possible themes occurred concurrently and/or intermittently with the conversations within the context of the group meetings. Individuals were encouraged to reflect on the dialogues and questions which arose from our conversations between meetings. They were encouraged to keep a diary or journal from which to bring ideas and stories to the next meeting. However, the main work of discussion of meanings was facilitated in the group. Most of the participants reported that they either found it difficult to set aside time for a journal and/or that they were not very comfortable with that process.

In this research inquiry the nurses not only participated in the production of the text for this study, but they also participated in the interpretation of the text. In producing the original text they were encouraged to speak of their understandings of their professional world in the fullness of multiplicity that presented itself.

We engaged in over a hundred 'nurse hours' of work together, which brought to speech literally hundreds of stories and our sense making of those experiences. For the writing of this text I chose to transcribe approximately 150 narratives (about 15 hours of edited tape) which I understood to be representative of many of the themes which reoccurred in our discussions. Parts of the final draft containing conversations and themes were reviewed by each participant as a member check of the accuracy of the representation and the appropriateness of the description of the themes. The response was an overwhelming affirmation of the authenticity of the edited presentation and a shared sense of resonance in the themes.

Some implications related to language and ethics

Central to my exploration is a very specific understanding of the relationship between language and one's perception of the world. I contend that they are co-constituted through the forming and informing of each other. In other words, our understanding of how we are in the world gives rise to our understanding of language and in turn that language influences our lived experience in the world.

I do not agree with postmodernist view of Foucault and Derrida that the subject is dead and that

> the self is only a "position in language" a mere "effect of discourse" (Flax, 1990). The subject is nonessential to their own analysis that concentrates on language, free-floating signs, symbols, readings and interpretations, all of which escape the concrete definitions and reference points required by the subject.
>
> (Rosenau, 1991, p. 43)

I proposed as the affirmatives do that the "subject is not inconsistent with the other intellectual orientations of postmodernism ..., however this will be a decentered subject, an 'emergent' subject, unrecognizable by the modernists, empiricists and positivists" (Rosenau, 1991, p. 57).

Giddens (1984) argues for decentering the subject but not for its demise. "Human beings employ language to communicate. Subjects, as agents, affect structure, but no action by an agent is meaningful in the absence of structure. The two are said to be mutually constitutive" (Rosenau, 1991, p. 59).

The conversations that the nurses in this study had together took on a very specific tone or style. Each participant seemed to understand that we were interested in the communication of situational interpretive knowledge, that is, how they knew about the world through their making sense of their own experiences. The focus was on experientially finding meaning leading to intersubjective understanding. Phrases that recurred frequently throughout the dialogues were "I think...", "I don't know, but...", "What do you...?", and "maybe...". There was an acceptance that each of us might, at various times, be silent in, dissent from, or be unfamiliar with, any particular part of the conversation, although frequently there was an affirmation and an exploration of shared understandings.

Once again the postmodernists in their deconstruction of texts are helpful here. They argue that their aim is to transform the usual understandings of both language and texts - "to undo, reverse, displace and resituate" the hierarchies implicit in binary oppositional discourse (Rosenau, 1992, p. 120). Nurses are usually peripheral actors in a rationalized, institutionalized, medicalized logosystem. The inversion of hierarchies in this study - in which nurses are central actors in a situated subject position - and the significance given to their words (texts) undercuts any traditional hegemonic or epistemic ground and also evokes a non-hierarchical epistemology and discourse.

Language is the way we communicate a world view to ourselves and others. Merleau-Ponty (1973) reminds us that "language is a treasury of everything one may wish to say... (that we can) recover the muted language in which being murmurs to us" (p. 6). Heidegger (1982) cautions us about how a formalized language can 'commandeer' (i.e., colonize) for its own purposes.

Hermeneutics and the postmodern critique argue that language is the means by which "truth" is transformed and subverted because language conventions suggest pluralism and relativism rather than neutrality and objectivity. Affirmative postmoderns see truth as personal and/or communal and theory of language as decentered, heterological and making no claim to a privileged voice. In this study by focusing on the daily life as evoked through the nurses stories, a multiplicity of experience emerges rather than an essentialist hegemonic voice of "The Nursing Profession".

In our dialogue together we were often aware of 'hospital language' which tends to 'enframe' all reality into a technological-calculative universe and to abandon 'natural language' or other ways of speaking. The participants often stopped and rephrased their descriptions to use other voices to tell their stories in a language that they felt spoke more authentically of their way of being in the intensive care unit. This often included metaphorical descriptions.

Narratives of nurse's practice often do not find a public voice. They are rarely articulated because, in my view, they are suppressed by a system which privileges the language of hierarchal power and rational technological thought. The nurse's voice has been disenfranchised by the dominant hegemonic structure. Nurses have learned to speak in this tongue in order to communicate about "realities" consistent in that particular (i.e., hierarchical hegemonic) world view. When nurses are invited to speak in any language that is consonant with their being in the world, rich diverse stories emerge from that understanding which is usually silenced. "Voice" in this study does not imply an essential position but that of a speaking subject, that is, the working towards a resolution which will respond to the dilemmas of authenticity and integrity in their lives.

As I have already discussed, my intention is to orient this research not only to honor the speaking self but to also affirm the importance of the listening self. Levin (1989) suggests that in the fullness of listening "is a recollection that demands of us the greatest openness to Being of which we are capable" (p. 219). He goes on to explain that it is this situatedness in listening that permits an "intertwining, the essential co-origination and interdependence of subject and object, self and other" (p. 220).

Gilligan (1982, 1988) in her studies of moral reasoning dared to claim the competence of a 'different voice' which spoke of care and relationships rather that the standard view of the ethics of rights and justice. Noddings (1984) further developed this ethics of care by emphasizing that we need to apprehend the reality of the other; an attempt to enter into the experience of another as much as possible. Grimshaw (1986) also stressed that it is "possible to attend to a situation, to try and see it accurately or justly ... the process of attention is in itself part of the moral struggle, not merely the final choice or the behavioral outcome" (p. 234). Iris Murdoch argued for a view that "facts" and "values" are connected and that we need to attend to other persons.

> I have used the word "attention" ... to express the idea of a just and loving gaze directed upon an individual reality. I believe this to be the characteristic and proper mark of the moral agent (Murdoch, 1970, p. 34).

Grimshaw addresses a postmodern dilemma in ethics by arguing:

> that the assumption of multiple ... realities, all of which are 'valid' and none of which have any claim to be regarded as more adequate than any other, cannot provide a way of conceptualizing things such as oppression, exploitation, the domination of one social group by another ... One cannot do without notions such as *improved* understanding, a *more adequate* theory, a *more illuminating* perspective (Grimshaw, 1986, p. 102).

This regard for others permeated this research both in its methodology and in its focus. I hoped to establish an attentive egalitarian presence with the co-researchers. I also heard this kind of 'attention to other' in many of the accounts of relationship in the nurses' stories. I am reminded of the following quote.

> ... the art of acknowledgement is probably the single most healing capacity we have as human beings. Really recognizing other people, whoever they are, whatever they're doing. Genuinely seeing them, recognizing them, and celebrating them. That sort of healing can reseed the planet with caring people (Tufts, 1990, p. 96).

Our experience

Ted Aoki (1991) speaks about how narratives allow us to begin to understand the questions yet unasked. The wisdom of this statement has become disarmingly apparent to me during this research process. The questions that appear at the beginning of each of the sections in Chapter IV only stood out clearly after hundreds of hours of conversation, exploratory dialogue and reflection on the part of myself and the nurses who joined in this inquiry.

It is not that the questions are sophisticated or particularly sagacious; on the contrary in retrospect many are quite pedestrian. That is precisely the quality of their value. One can name the destination most accurately after the journey is taken. Those of us who journeyed on this inquiry were able to explore by foot a terrain for which we had no maps, a countryside that had not been definitively marked and encompassed by a prescribed ideological perspective. Certainly we each brought with us the views from our own experiences, our own subject positions. We often marvelled at the similarities, delighted at the differences and explored the inconsistencies.

Although the process was far from sequential, it may be useful to think of five patterns of situations which seemed to recur during the research. These were impressions, stories, conversations, reflections and questions. I have already commented on how the questions only seem to surface when we were in the middle of the understanding of our stories. Let me comment briefly on each of the other four experiences of process.

The 'impressions' were the integrated consciousness of recurrent words, familiar themes, significant inflections, meaningful pauses that we each took in or created during our time together. These seemed very trustworthy and powerful because they formed the fundamental strands out of which we would weave our understandings. The nurses became both at ease and engrossed in the elemental quality of our time together.

Of course each participant had a different experience of words and phrases depending on the understandings they brought to the encounter. An area which fascinates me is the large extent that we seemed to share 'harmonious impressions'. The commonality of the elements was striking, where we differed were specific examples in our lives.

Those examples often took the form of "one time...". In the first one or two meetings, each member of a group would often take turns giving a "speech of a story" while their colleagues listened, making inquiry or giving additional comments when the story was completed. However, very shortly, the 'telling' took on much more complicated forms. Often a speaker would go on to a 'sequel' or a variation on the theme to try to convey their understanding of the nuances of the story.

At times there would be a series of four or five stories by two or three individuals offering parts of a collage to elaborate on the same theme. On occasion when there seemed to be lot of synergistic energy in the room, two or more individuals (strangers to each other before these meetings) would tell the "same story" taking turns fitting in chunks of their different stories into one that took in an almost generic or archetypal quality. I don't think this 'joining in' was planned nor explicitly thought about. The sharing was often palpable. Touching stories at times brought tears to the listeners eyes; spontaneous bursts of laughter were frequent. If you view the videos with the volume off we might be mistaken for a class practicing beginning sign language. In reviewing the videotapes later I was amazed at how we seemed to be oblivious to sirens, jet planes, noises in the hall and most of all to time. There were often comments of surprise when someone glanced at a watch after 2 hours.

The activity that I experienced more specifically as 'conversation' was an exchange of ideas. There was a quality of problem solving, fact finding, negotiating and exploring meanings of words. There was a sense of filling in more detail, which was most apparent when the focus shifted to an area that we had not previously explored.

Reflection was evidenced in both short term, that is periods of quiet and questioning, and in the longer time frame of the entire study. Many statements began with words like "You know since we talked about that last week, I've been thinking...". Before I began this process I was concerned that a few "strong personalities" might dominate the discussions and put closure of exploration with the 'right' answers. However the concern was unwarranted; the participants evidenced a great deal of respect for and interest in what their colleagues were saying.

Their discussion demonstrated the qualities which van Manen (1991) suggests need to be present in order that an account will offer an appropriate text for hermeneutic, phenomenological exploration. He describes the desired qualities of the accounts to be oriented, strong, rich and deep.

I experienced the narratives and dialogue of these nurses to illustrate these qualities in the following ways. The quality of being oriented permitted them to look seriously into their experiences in order to find meaning. They were strong in trying to be as perceptive and discerning as they could be. They provided a rich text that is anecdotal, evocative, showing a fascination with real life experiences. They offered deep interpretive descriptions, restorative of meaning, reflective of how they stand in life.

I believe there was evidence of the special listening that Levin (1989) calls "hearkening". He describes this way of listening as an attunement to another that goes beyond the tendency to hear with ears that belongs exclusively to ontical everydayness. In these groups there seemed to be a letting be, a letting the other speak, that was ethically alert, attuned to the silences, and to the speech. They were not forgetful of the vibrant matrix of their being together, belonging together in their speaking/listening. They were heedful not only of words but of inflections, pauses, facial expressions and body languages.

I requested that each participant write a short biographical sketch to introduce herself to the reader. This is in keeping with the subjects claiming their own subject position. They have chosen the details that they felt were relevant to the reader's understanding of their person as a nurse. Almost all participants chose to retain their real first name; this seemed to be in harmony with the personal affirmation in finding listeners to their voices.

The notation (P) after a name indicates that the nurse was a participant in the pilot study; (M) indicates those nurses who took part in the main study.

Introducing the participants

Chris (P): I have been a nurse for almost 30 years. I agreed to take part in the pilot discussion group for this research while completing a post basic degree in nursing.

I am married and have four children who are now young adults. I feel that I have always wanted to be a nurse so that I could help others who were like my younger sister. She was physically handicapped and thus was hospitalized and separated from us for long periods. For me, this explains why when I think I am really effective with a patient, that the connection feels like a family relationship.

My initial nursing experience in medicine and surgery was the preparation to become an educator, first with nursing students, then with hospital staff and lately with patients. My most unique experience was in the role of patient ombudsperson.

Heather (M): I am 39 years old and have been in nursing for 20 years. I had always wanted to become a doctor when I grew up, but at the age of 17 was faced with the reality that to be accepted to medical school in the early 1970's was an uphill battle for females and decided to become a nurse instead. Over the years I was grateful that I had become a nurse instead of a doctor as I feel that it gave me much more satisfaction than the medical profession ever could. I worked for 11 years in critical care settings, obtaining my undergraduate degree during this time. I have also spent 5 years as a community health nurse in northern Canada. I am presently attending university to obtain my master's degree and also work on a casual basis in a rural hospital. These two circumstances, along with my years of community health nursing, have led me to the conviction that I no longer wish to work in a hospital setting. I still enjoy the essence of nursing, but have developed a strong dislike for the context within which nursing takes place, that is, the Canadian health care system. However, I am grateful for the years that I spent in critical care nursing, as I believe that it has had a profound influence on who I am today.

Janet (M): I was born in Southwestern Ontario and at age eleven, one of my older brothers died of leukemia. The impact of his death upon the family and myself made me realize that I would "help others" in the future. Consequently, I became a candy striper at the local hospital and after high school I worked full-time as a nurses' aide. Deciding that nursing would fulfill all those "caring" needs, I spent two years in a community college program and graduated in 1980.

I commenced my nursing career in a small town in Alberta where I acquired the ability to be a jack of all trades. I worked for several years in a variety of ward settings in several provinces. I took an O.R.

course but decided that I wanted more patient contact. I then enrolled in a critical care course and it has opened doors to another world!

I began in a CCU which offered benefits of personal touch, lower patient ratio, a sense of responsibility and respect for increased knowledge and skills and camaraderie. These were my building blocks for the future.

Presently, I work in a cardiovascular surgical area. Technology has made me aware that there are limits to which everyone and everything can be pushed; this unit has forced me to experience many conflicts regarding "ethics".

Sue (M): I have been practicing as a RN for 10 years. I worked on a Thoracic and Vascular Surgical Unit for one and a half years but I found the work very heavy. It was like a factory, people would have surgery; then we would ship them out and wait for the new set of people. I did enjoy this experience but I wanted to work in an intensive care area. I also felt that pediatrics would be a good area for me as children are so innocent and vulnerable and therefore need people to care. I worked in a Neonatal Intensive Care for four and a half years and then an Emergency Room for two years. Presently I work on a casual basis in both NICU and Emergency while going to school to obtain my BScN.

My decision to return to school was in some ways an act of desperation. I had grown to greatly dislike the bureaucratic structure of a hospital. I felt there was little say for me as a staff nurse. Going back to school has greatly changed my perception that nurses do not have decision making power. I still believe that nurses could be better utilized in the hospitals but I now think we can have more influence. This is part of my evolution as a nurse.

I have a deep belief in God. I attend a church on a casual basis. To me life does not make sense without believing that there is a reason for the occurrence of various events in our lives and that God is always there for us.

My family is four in number. I am the oldest, my brother is nine years younger than me. Presently, I am 30 years old. I would say as a family we are closer now than we ever have been because we have learned to accept each other as we are. My mother and I have an especially close relationship. Also, this summer I will be getting married.

I decided to become an NICU nurse because several of my friends worked in the area and were both challenged and intrigued working in this area.

Nancy (M): What I have looked for in nursing is something that would challenge me and allow me to grow within the profession. Once I became comfortable and competent in general duty nursing, critical care nursing seemed like the next natural step. However, after a few years in that area I again became restless and felt restricted. I have moved into the nurse practitioner role and also furthered my education. I don't think I'll ever stop trying to grow and seek new challenges.

Noella (M): I obtained my diploma in nursing later on in life when my children were in their teens. I have always taken pride and felt comfortable in tending to others. A strong faith has helped me through many difficult times in life and continues to sustain me. I feel very strongly about being a patient advocate and making my work place as enjoyable as possible. I've been full time in a cardiovascular ICU for four years, currently I also work an occasional shift in a general ICU and volunteer as a medical emergency flight nurse on a regular basis. My outside interests include cycling, gardening and crafts.

Marie (M): I am the eldest of eleven children, and spent most of my years growing up on a farm. My mother died when I was still young (age eight). I came to terms with her death at approximately the age of 16. My growing up years, were years of schooling and doing chores about the house and taking care of my brothers and sisters.

I completed my nursing education via a diploma program and since have taken continuing education courses in critical care nursing. For the last ten years I have worked in a coronary care unit and prior to that worked in pediatrics.

I am married and have two daughters. I am Catholic and the choices and activities of my life are strongly motivated by my belief in God.

Maureen (M): I have been a nurse for 10 years. I have always worked at neurology or neurosurgery. The brain fascinates me. I now work in a neurosurgical ICU. I have worked there for 5 years and always feel I am learning and growing.

I am the eldest of 3 girls. Education was very important to my family. My mother is a retired nurse. I am divorced, and have no children. I will be 30 this year.

Sandy (P): I am the eldest daughter in a family of 7 children; there are 5 boys between my sister and I. As a child I often cared for the younger children; relationships with the family remain an important consideration for me personally and professionally. My husband of twelve years and a new puppy make up my "grown up" family.

I graduated from a nursing diploma program 20 years ago. During the years since graduation I have worked in pediatrics, nursing audit, and most recently in the community. My work in the community has been somewhat non-traditional in that on separate occasions I have worked as a rehabilitation counsellor and case manager with individuals receiving Long Term Disability or Workers' Compensation as a result of illness or work related injuries. Insurance and compensation systems being what they are, my relationships with claimants were often almost adversarial in nature. I believe these adversarial relationships as well as being isolated from other nurses in both of these positions had a detrimental effect on my image of myself as a nurse and acted as a catalyst for my return to school. I needed to get back in touch with nursing; to reaffirm why I had become a nurse and what nursing meant to me. Returning to university full time in 1988 to complete a post-basic degree was a scary but wonderful experience. It was so wonderful in fact, that after only a brief break from the classroom I began full time studies in the Masters of Nursing program.

Shauna (P): I have been a practicing nurse for five years. I was first employed on a very active thoracic/vascular and general surgery unit. While the workload could be overwhelming at times, I thoroughly enjoyed the education I gained from the clients presenting on our unit. Many of our clients were from the inner city; unemployed, homeless and a wealth of accumulated life experiences. I had the opportunity to listen to and learn about situations and realities I may never otherwise developed an awareness to. The experience continues to aid my growth personally, and in turn, as a professional.

I transferred into the medical/surgical float pool when I decided to further my nursing education pursuing a post-basic degree. I completed the degree with a new interest in bioethics, in addition to a renewed enthusiasm for my chosen profession.

Returning as a staff nurse to thoracic/vascular and plastic surgery, I also assumed the role of unit-based quality assurance liaison, I found this to be a rewarding challenge; helping co-workers identify needs and develop solutions to deal with problems.

I have always remained extremely close with my family. My grandmother never ceases to surprise or inspire me. I know as I look forward to the next four months in a critical care course, I can draw on their love, support, and understanding.

Terri (P): I have a background as a respiratory therapist. I decided to go into nursing, but to retain my R.T. license. I have always found "the need" to help, to care for, and to make those around me happy, healthy and comfortable. My mother has a chronic respiratory illness which contributed to my choice of professions.

I am the middle child of three sisters, all of whom are nurses. We all have different nursing focuses. I am the Palliative Care Program Coordinator in a rural community. I have a BSCN and a gerontology nursing certificate. I love working with the elderly!

****

Needless to say there is no claim nor intent that this group is representative of anything other than themselves. It is evident that we can speak only from our own subject position(s). We are white Canadian working/middle class women in our twenties to early fifties, of Christian background. Certainly some positions who are presently in critical care nursing do not have a voice in this particular research. These subject positions include women of colour, men and individuals from non-Christian traditions to name a few. Hopefully other research inquiries will provide more diversity to the chorus of voices in order to broaden our understandings.

CHAPTER III

AN OVERVIEW OF THE THEMES: SETTING THE STAGE

Central Yet Marginal

Nurses find themselves in the very center of all that transpires in the intensive care setting. Literally and figuratively they are the hub of communication, coordinators of activities, the interpreters of all languages. They are expected to show initiative and independence and yet they are on a short tether to physician's orders and hospital policy. This central yet marginal position is an excellent example of how this creates difficulties. In nurses' professional lives, simultaneous and yet discordant positions are often juxtaposed and elicit competing self images.

These apparent incompatibilities give rise to further disharmonies and complexities in their relationships with others. The patterns of themes that evolve from the nurses' narratives speak of their struggle with a great number of competing images. The multiple tensions in these diverse representations are antithetical to a single understanding of 'the nurse'. For example, how can we portray this nurse to be an originator of valuable trustworthy speech and at the same time see her as a deferential reliable conduit of others' words? It is not that an individual cannot do both but if we were scripting a play, the image of the actress would be cast very differently if the main impression one wanted to convey for this character were one or the other persona. These nurses' stories overflow with complex multidimensional imagery in all aspects of life from the trivial to the profound. How can we begin to think about these diverse collections of ideas that seem to emerge from how the nurse imagines herself. The phrase "imagines herself' is much more informative than speaking of "her identity".

'Identity' denotes

- the quality or condition of being the same in substance, composition or nature

- the sameness of a person or thing at all times or in all circumstances
- (in psychology) the condition of remaining the same person throughout the various phases of existence... (Oxford English Dictionary, 1971).

The focus of this word is definitely on what remains unchanged. Kristiva (1986) disagrees with this notion of stable identity arguing that

> the new generation of feminism or more accurately, the corporeal and desiring mental space now available to women is one that advocates the parallel existence or the intermingling of all three approaches to feminism (egalitarian, radical and postmodern). Presupposing as it does the deconstruction of the concept of 'identity', this demand opens up a space where individual difference is allowed free play. (p. 188)

The narratives in this study lead us to examine many variations and differences interpersonally and intrapersonally. Therefore the appropriate construct for this inquiry is that of 'image', specifically the image the nurse has of herself. The noun 'image' and the verb 'to imagine' are particularly well suited to carry the necessary connotations.

An image is conceived or created

- a picture in the mind, represented to oneself
- to portray, reflect or delineate
- to describe vividly in visuals, speech, or writing
- in symbol, metaphor or emblem
- something to be executed; to devise a plan.

When we imagine we form an idea or notion with regard to something not known with certainty.

- to consider, ponder, meditate in the hope that this creative faculty of the mind in its highest aspect has the power of framing new and striking conceptions of poetic genius
- to conjecture, guess, suppose, often implying a vague fanciful notion not founded on exact observation or reasoning
- and to scheme, devise, plot a project - an impression as to what is likely, expected or anticipated.

(edited from OED)

These nurses vividly describe in their narratives how they conceive their own images and embody their idea of themselves. This portrayal of how they are represented delineates how their lives are to be executed in a particular context at a given time. This is intermittently perceived as creative genius, fanciful conjecture, a scheming plot, or prescribed outcome. These images of self elicit many emotions in the imaginers: such as pride, hope, delight and empowerment; as well as shame, resignation, sorrow, anger and all other shades of feeling in between! "Image" in this context is a very potent word.

Constellations of Themes

In the work of delineating themes for this study many patterns in the nurses narratives were weighed as potential organizing strategies. These were indeed myriad, considering the pervasive condition of multiplicity. The structure that will be proposed for a better understanding of these images comes from the aggregation of two main clusters of themes.

'Theme' in its most commonly used meaning describes the subject of discourse, discussion, conversation, meditation or composition. (OED) In this text, themes are intrinsically related to all and to each of these activities. Additional understanding is offered by the use of 'theme' in music; the principle melody ... also a simple tune on which variations are constructed. In the case of this research, the variations of experience were encountered first, then an attempt was made to bring the tune or melody to a notation on the printed page. Each 'notation' in the thematic outline was given form by patterns in specific stories and conversations. These constructions were brought to their current form by the original speaker, by the participants present in the conversation and by the editing and continuing interpretation by the author of this text.

The two constellations of descriptors of these themes emerged from the tone or attitude of the storytellers. The first collection of themes came from those representations that the nurses identified as positive, ways that they really valued in relationships in their professional lives. The second association of themes were seen as more negative images, qualities that recurred in the stories that were problematic or less desirable although they were often deemed as necessary in the context of the task. It is not a simple dichotomy or dualism. Most elements of their experiences did not sort neatly into one of the groups. Also there were many variations among participants.

Often an individual had ambivalent feelings over a given scenario as will be seen in the narratives. However, these themes did recur frequently and with enough consistency to sketch in an undeniable impression or pattern. These two compilations of themes in relationships are not meant to appear as definitive, all encompassing or the 'final word'. There is a pernicious tendency for ideas to take on that quality when they are rendered into lists, diagrams and models. Page 84 will offer an outline of those two constellations. This is a preview of the themes that will be explored in their original subtlety and complexities as they permeate the nurses accounts. But before the outline of those themes, it will be useful to digress momentarily to the narratives of how the nurses perceive that they have come to be oriented into ways of imagining themselves living in the world.

To Know Where We're Coming From

The nurses describe many responses to being in the middle of heterogeneous expectations and diverse images. They speak of feelings of conflict and confusion. They name this tension as the cause of rebellion, withdrawal and 'burnout'. Sometimes they speak of it as an opportunity for creativity, integration and the possibility to become clearer on the personal priorities in a context which is constantly in flux.

During the last few minutes of the last discussion Sue described her journey this way:

> *When I was coming here this morning I was just thinking about this whole experience. My initial thought was, maybe I could make a little bit of sense out of the relationships; I don't know if I have but I just feel better about it. It makes more sense in a different way than I thought it would. I can't explain anyone's behaviour but now I have more acceptance of my own behaviour. Maybe that's what*

> *is the most important thing; to know where I'm coming from and be real clear on my goals in my profession and what I'm doing. I will work towards those and not worry so much about my relationships with other people.*

The idea that an important way of making sense of our relationships is to know where we're coming from, be clear on our goals and our actions was a prevalent conviction among the nurses. I will set the stage for the narratives of relationships in professional practice with a discussion of how these nurses construct their own image(s) in their past.

One of the striking patterns that was evident during the nurses conversations was that they envisaged their life as a whole. They seldom categorized their lives as being in the private sphere as opposed to the public sphere. That distinction came up occasionally as 'context' but it was not seen as requiring a different image of self. On the contrary, although it was not specifically requested, many stories went back to childhood experiences and educational experiences to explore the roots of the current events. There was often a sense on the part of the nurses that the continuity in their personal history, their own current situation and their ongoing evolution were each best understood in the matrix of their entire life. This characteristic in their stories offers a further understanding of the feminist phase "the personal is political."

Discussions on how and where we have learned to relate seem to center around four overarching motifs. These will surface again in various forms in many of the narratives from nursing practice. They are first, being there for others; second, quest for challenges; third, a mature perspective and fourth, women are different.

Being there for others

Heather: *When I grew up, my mother always made sure that I looked at the other person's point of view. I can remember coming home and complaining about a teacher and my mother would just infuriate me. Instead of saying "Yes, dear, you're right; he's a terrible person", she'd say "Now look at it from his* *point of view" and she used to do that all my life. And I could look at it from that point of view - put myself in their place, see how they feel, why did I think they are acting like that. It hasn't made me a perfect person by any means and I can be quite intolerant but I think I'm a kind person. I don't like to hurt people's feelings.*

I can remember when I was little and something would happen and my sister's feelings would get hurt and it really affected me. One incident happened when I was four years old and she was six years old and we had gone shopping. I was going to a birthday party and my mother had bought a toy for this friend. My sister at first thought that this toy was for her and was all excited. My mother explained that no, it was for this friend. She was quite disappointed. I was only four but I remember feeling terrible! I said to my mom, "Give it to her any way and I won't go to the birthday party." I've hurt people's feelings but I don't like to hurt their feelings. If they make me mad I might, but for patients, really, they are pretty defenceless. Whatever their life style or whatever they did that put them there, I still think they should be treated with respect and how I would like to be treated if I were in the same position.

I've been a patient in emergency because I was having an appendicitis attack. I guess by about seven o'clock, the surgeon had seen me. All my blood work was done and I was just waiting to go to ward. I didn't get to the ward until about 10:00 at night. Nobody in emergency came to check me to see how I was doing! So, now when I work in emergency, I always go through and just say, "You aren't forgotten," or "Can I get you anything or do you need another blanket or, would you like a pop or would you like some water?" It is good to be a patient because there are little things that I did that I didn't know how helpful or annoying they were.

Sue[1]: *Or what's really helpful! - what really works! I know one of the things I've done in the past, I've categorized people. "They are like this because they do this" and I realize that's not true at all. Everyone is so individual. I mean, I can learn through other people especially about grieving. I had been told these things about grieving in the NICU. When a baby died, either the parents would come together and grieve together and cry together or they'd be on opposite sides of the room and be grieving. I used to think, "That's not a good sign! They should be together." What did I know! When I think back, that just seems so stupid. I don't know where I got it from, maybe somebody told me. But now I realize you need your moments of hugging someone; you need your moments of just being alone. I think that's stupid to put people in categories.*

I think a big role of my growing up was to be a supporter. I think that was part of me before I came into nursing. I learned it somehow because people responded to it. It seemed like something that they could use. I always felt that being there for people was really important. Therapeutic for me and for them.

Heather: *I think we sort of set ourselves up to 'everything has to be perfect', everything has to be done for your patient. You have to be able to keep an eye on all their vital signs, and their ECG and everything and catch it before anything goes really wrong. If something happens, you think, "Oh what did I do, where did I go wrong, what didn't I notice that I should have noticed! Why didn't I talk to the doctor or why didn't I explain it better to the doctor so he took it more seriously."*

---

[1] Sue's grandmother had died after a brief illness the week before this conversation.

And then when you are in charge, you not only have your patients. You have all the other patients and all the other staff and I always feel a big responsibility for the staff too. I mean they may be not new staff but may be people who have worked as long as I have and have as much expertise, but it's a strain for them. You are worried that they don't get their breaks; you worry that they don't get a chance for lunch; you worry that they don't get the help they need to turn their patients; that they are not going to get off on time. You worry that the place isn't going to be nice and neat and tidy for the next shift that comes on and.

Ann: *Where did we learn to worry like that?*

Heather: *My mother! (laughter) I think it's socialized. I think by the time you start you are taught to put the patient first. And I don't know about you guys but when I went through nursing education, it was a three year nursing school and you were service on the wards. The wards were staffed by student nurses. You were taught that you did everything for the patient that you could and that doctors were very important and nurses weren't very important. I really just got into this mentality where everything was my responsibility. My mother has always felt very responsible for how we turned out. If anybody has troubles, she asks where did she go wrong. You know, my brother got a divorce and she's wondering where she had gone wrong.*

The reason why I went into intensive care is that I wanted something that was a challenge. I wanted the excitement and I wanted the technology and sort of the rush. For the first four years I worked in intensive care, I just loved being busy all the time. I loved being assigned to patients with multiple system failure or trauma patients where it was busy, busy, busy working hard. Later I decided I liked

> *it when it was quieter and you could spend more time with your patients and it was less of the rush and more of the relationship we develop with the patient or with the family and with the rest of the staff.*

In this conversation Heather and Sue tell of how they 'learned at their mothers' knee' to be a supporter, to be tolerant, to be kind and put themselves in the other person's position. This has been reinforced when their own positions have been those of patient, patient's family or nurse. However there are some subtle but important differences in how they imagine themselves to be there for others. What are the nuances of this caring, this way of responding that is "therapeutic for me and them"?

On the one hand, we hear that we have the duty to be self sacrificing, to be responsible, to worry about and care for everybody. We set ourselves up to work hard, make everything alright for people who fit into the categories that someone has told us about. These nurses are questioning the wisdom of that kind of 'caring'.

At the same time we harken to quite a different message in that what is really rewarding is just to be there for people, to see them as individuals and not to forget them. It is important to pay attention to details, to tune in to the disappointment of a sister or the strain of coworkers.

In the last paragraph Heather tells us how she can embrace the challenges of busily doing things in the technological aspect of intensive care and still value time spent in developing relationships with others. Possibly, the intensive care unit offers the perfect setting to be there for others in the multitudinous and diverse ways of which we are capable.

Quest for challenges

Nancy: *When we were sick, my mother's comment would be, get up and get dressed and help her around the house. You'll feel better! My mother definitely believed that 90% of the illness was in the mind and therefore we didn't get to stay in bed.*

> *I can remember one time after I had left home being sick*

and her phoning me and I had to crawl to the phone because I was so weak. She sent my sister over because my dad had just had surgery and my sister was saying, "Mom feels really bad that she can't come over." I said, boy, I wouldn't survive mother's visit! (laughter) She'd want me to get up and get dressed and clean the house! I won't say that my mother was uncaring but she'd never been horribly sick and she had no empathy for somebody who was ill. When she finally got ill herself, she had no patience for herself.

And I've bought into that philosophy for myself. I accept other people, but when I'm sick, I remember that part of "it's in the mind". Although I don't necessarily want to, I feel I should get up and do things.

When I was young I just wanted to be a nurse. I was very idealistic and salaries were nothing then, I mean, nurses were below minimum wage at that time. What is important to me is that I enjoy what I'm doing and in later years nursing, I wanted it to be a challenge. I wanted it to test me and test me at all levels. But I don't think at 18 that's what was drawing me. I just think it was where I felt I belonged.

I went to one of the old schools of nursing, definitely there was socialization to the extreme. The psychologist at the hospital accused them of Neo-Nazi techniques. You didn't take a breath without permission. Expectations were very high, very regimented, very controlled and we were socialized in that manner. I think that's where the change in my values took place because all of a sudden, "getting by" wasn't good enough. I mean, even when we were in the residence, our profs knew who had studied for exams and who hadn't. They marked exams and papers with that in mind - so you had to put the work in because it was important to them. The house mothers would tell them who studied.

One thing that's become apparent since I've gone back to academia is that nurses have extremely high expectations of their performance. When I was in my undergraduate program, one of the philosophy profs and both of the sociology profs said that you can pick the nurses out of a crowd because they are the ones that want all the details on what is expected of them. When they are doing assignments, they are in the office 25 times getting clarification because it isn't enough to do a paper, they have to somehow produce this perfect paper. I think it's because we deal in an area where it isn't okay just to do a mediocre job on the patient. You have to do your best and that translates into other aspects of our lives. It isn't okay just to get by, you have to do the best possible job.

********************[1]

Nancy: *The first year that I worked in ICU we had a lot of patients admitted with overdoses. There was one thing I couldn't understand. We'd have somebody here in this one bed who's fighting for their life and in the next bed a little 17 year old twit who slit her wrists five times - like grow up! And I'm having to spend time on her when he's the person I should be helping.*

I think I'd worked in the unit three years when I met this patient who tried to commit suicide. All of a sudden, I guess it was a revelation that somebody can hurt that bad! It was a lady who had tried an overdose. She hadn't taken a lot so she was conscious the next morning. She told me that she had a husband who didn't batter her, but basically he had married her because he wanted someone to keep house and raise his children. He was away Monday to Friday at his job and

---

[1] A row of asterisks indicate that a substantial section of transcript has been omitted but that what follows ties in thematically.

> *came back Saturday. I mean she wasn't an entity, she was truly a domestic and somebody for him to have sex with and that's all she was.*
>
> *She'd gone to a G.P. and tried to get help other ways and nobody listened. I guess she thought "If I try to kill myself I'll be admitted to hospital and maybe someone there will get me the help I need." I still wasn't all that sympathetic until her husband came to visit and his first thing was, "When can she be discharged 'cause I'm stuck taking care of the kids". And I thought, "Yeah, this woman probably was at a point where this was the only light she could see." But I still can't condone it. I could never see myself doing it, but maybe there comes a point with some people that they just can't see any other way. They are just so very deep in it they can't imagine another way. It seems like your career's marked with these moments where you have an illumination about something.*

In this series of excerpts which surfaced over the course of 2 or 3 hours of conversation, Nancy tells how she developed high expectations and regimented herself. This lack of patience for anything less than perfection carried over to her view of patients behavior in early years of nursing. Then a woman who "hurt so bad" because "she wasn't an entity" gave her a "moment of illumination". Poetic justice? Maybe.

Nurses often told a series of stories that spoke of their own periods of being "just so very deep in it, that they couldn't imagine another way" and then their experiences and reflections that offered the revelation of other possibilities. Images that reflected and encounters that revealed other becomings. Our professional journey is often marked by moments when the light of understanding another's life shines through to enlighten our own life.

Nancy speaks of two ways of being "your best". The first is a view from the high ground. What is required is that the self be as perfect as possible. You are judged by your performance. You are to stay in control and conform to rules and to high minded expectations. The self is socialized into a role in an hierarchical structure of performing your task through hard work. This is the story we hear of her youth, of her experiences in nursing education and of her expectations of patients in her first years in ICU.

Then in the last story we hear of a conversion in which she recalls first being illuminated about a different way of looking at the self. Here we behold an image of self struggling to become an 'entity'. This is an evolution into an existence which is more than the sum of its functions and qualities. There is an acceptance of self as embedded in life. The person desires to be a subject, an agent, not an object or persona. Nancy saw herself and the woman as enfolded in the matrix of life. "Matrix" recalling its origins as womb - a place in which someone can safely develop. This metaphor of matrix does not speak of high places, in fact it evokes the lyrics from the song, Low to the Ground (Roderick, 1991).

> Its music that keeps us alive
> Its dancing that sets our hearts free
> Its children remember the laughter in life
> Its animals teach us to see.
> Stay low to the ground
> Live close to the earth
> Don't stray very far from your soul
> Its simple things show us the reasons we're here
> And its simple things keeping us whole.

Prophetically, insightfully, Nancy says she values nursing because "I wanted it to be a challenge, I wanted it to test me and test me on all levels."

A 'mature' perspective

Marie: *I decided at the age of eight that I was going to become a nurse. I'm not totally sure why except at about that time my mother died. Maybe I decided at that time to become a nurse so that I wouldn't get sick and so that I would be able to know what's going on and to be able to stop any disease process. That may be why - it was such a quick decision. So I worked toward that goal.*

****

Marie: *I think having my own children has a lot to do with how I relate to other people. I changed a lot after my first daughter was born and I think maybe that's it. It changed me there. I became more patient and more aware of other people, a bit less selfish. I think if I went back to work in Paeds now I might be a better nurse for those children. Technically I might not be a better nurse because I wouldn't want to inflict the pain. But emotionally and feelings of love that I could give them, would be more pronounced than it was before I had my children.*

****

Maureen: *My mom was a nurse but she never told me what nursing was like. I liked people but I was very naive, and not very sure of myself. I went into nursing and it really changed me! I think it really matures you quickly compared to the other people that are the same age. You see people die, you see what people go through.*

Nancy: *Yes, I agree that nursing forces one to grow up a little quicker. I remember being 21 having just graduated, and working alone on nights on the floor one time and thinking, "My God, I'm responsible for these lives!" Also, I can remember going back from nursing school to where I live, on a weekend towards the end of my training and being with my peers from high school. We had lost a lot of what we had in common because I was dealing with life and death and they were still dealing with having fun. There was the beginning of a gap there. There's this maturity that comes with the positions you put into.*

Maureen: *I think it also puts a lot of stuff in perspective. If I am feeling down about something, all I have to do is go to work. "Oh my Lord, look what all these people are going* *through!" It kind of makes you feel, I shouldn't feel sorry for myself. There's a lot of worse things that could happen, even if it hasn't happened to me personally, I can see what other people are going through and that kind of puts things into perspective.*

****

Chris: *As an instructor of beginning level nursing students, there were students that had various different qualities that I sensed would make excellent nurses. I have had the opportunity to work in the same environment for a number of years now and I haven't very often been wrong about my judgements in this matter.*

There is a movie that's a very old one and it's called "Mrs. Reynolds Needs a Nurse". I actually had a contest with one of my peers, who was also an instructor. I said, "When we take all our students in to watch that movie, I will go in with an armload full of kleenex boxes and people who come to me, part way through, or if I pass the boxes down the row, the people who would openly take a kleenex and openly show you their emotions during that film, I would take all of those students into my group and I could guarantee they would be excellent nurses." My crusty confrere said "No way, I don't want any of those weeping bawl babies".

We teased each other over the years. I was never disappointed in that characteristic or that quality in students. I don't think there is anything profound or technical about it. It's just doing what comes naturally. I don't know how to explain it.

These extracts from several different discussions tell how the nurses assess the process of maturing. Chris suggests that it helps if one comes with a natural openness to the pain of others. Life is put into perspective and we are changed by seeing, by being present, by being responsible for life and death. Lessons from personal lives and from professional experiences are not seen as separate areas of knowledge.

What are the perspectives from these particular mental points of view? How is the appearance of the life-world altered by the relative position of the participant? In what way does the death of a mother, the birth of a daughter or the tears for the suffering of another help us to mature, or complete the natural development of our growth?

In the 14th century, an early use of the word perspective was for an optical instrument for viewing an object; a magnifying glass or telescope etc. To look through the wrong end of the perspective meant to look upon something as smaller or less consequential than it is (OED).

Maybe these nurses are talking about acquiring a position which offers a maturing perspective in order to see things in their appropriate consequences. They acknowledge a technological, material world but also speak of a growing appreciation of the humane, the natural and that which is often ineffable.

Women are different

Janet: *I had a brother that died of a sudden terminal illness. I saw how that affected our family and how my mother cared for the rest of us because of the caring attitude she had. Because of all the diversity around those circumstances and seeing how people dealt with death, I thought that by going into nursing, I could handle other difficulties better. I understood from the things that were said to me or done for me at that time that I could have some importance for making life a little bit less troublesome for someone else down the road.*

Noella: *That just made me think. When I was a youngster, I can remember my older brother was sick and my mother had made him some jello. Whenever anybody at our house was sick, oh, you just got the most tremendous care! I can remember being bustled out of bed in the morning into a nice warm bath. While you were in the bath, your bed was remade and there were* *nice, crisp sheets on it and fresh jammies and back into bed and it was just so clean and neat and everything. I can remember one day, I was taking a tray up to my brother. I guess it was jello and it hadn't quite set. It was still kind of runny and the tray was kind of messy. I was just a little youngster then and I was going upstairs and mom came down and she said, "What is this!". I said it was for Wally and she said, "Oh, honey, you can't take* *__that__* *up there!" I said, "Well, he's sick, he won't even notice it." She said, "Oh, when you're sick, that's when you need to take extra special care." I've never forgot that, you know. It just seemed that little bit extra is what you had to give and so I think that has influenced me.*

I did a lot of things over a period of years like secretary, driving truck and then I started into accounting. And it was between accounting and nursing. I put about a year's thought into it. "What do I really want to do? Do I want to work with papers or do I want to work with people" and the people won out. I just loved the contact with people and so when I told my daughter that, who's now in nursing, she asked me what nursing is all about. We talk quite frequently on the telephone and I tell her what I feel about ICU. To me, it's all positive. I love my job! Although sometimes you just feel, "Geeze, I don't know what I'm doing here." As soon as you get into the nitty gritty of work it's great. Sometimes you hear the report on your patient and think, "Oh my God, what am I going to do with this person!" Then you get in there and it just seems like a challenge and I love the challenge of the work. I love to be able to go in the morning and see this very critically ill patient who is not doing well. Then, through the skill that you've learned and everything, leave that patient that night clean and tidy and *relaxed and doing better. That to me is the challenge of my work. It is to be able to make somebody else's life a little bit better and it doesn't matter if it is in ICU or anywhere else.*

****

Noella: *Bob says there should be a course for husbands to take to know how to debrief a wife because there's times when I've kept him up crying - crying all night - totally, almost inconsolable. You don't know what to do. You just sit and cry and cry. And we've talked about how do the husbands deal with it. A lot of the girls don't even tell their husbands.*

Well, Bob at first said, "I don't want to know." He said, "You're just a glorified maid." That's what he thought nursing was at first. And then I finally got him to come into the unit. He wouldn't come in for a long time. And finally, when he realized it, then his whole attitude changed.

I think it is the technology that's impressive. Like on the ward where you go in, you make the bed, you bath them, and you assess them and all that. In your mind you're doing a lot of stuff, but it's not visible. But where I am now, it just impresses the hell out of him.

He's in plastics. I took home stop cocks because he knows moulding, injection moulding and he'd tell me all these different kinds of plastics, and I took a swan ganz catheter home and showed him. He said this is just amazing technology! He was fascinated by all that and he's kind of progressed on to be interested in the equipment that I use. So I think that's what's made me go up in his eyes, not the fact that I'm nursing critically ill patients, just that I know how to run a lot of the machinery. He can't understand how I can't set the alarm on our clock radio! (Laughter)

Janet: *One of the discussions my husband and I have had is, "whose job is more stressful?" He could come home after a bad day and say, "Oh, I had a really bad day!". He may have worked on a $2 million machine. But I said, "If you screw up it's only a part. It's tangible and it costs money, but it's not a life. It's not somebody's loved one. If I screw up, it is totally different." And it wasn't until we had gone to a third party who could explain both sides of the coin to both of us, that he realized how much emphasis and responsibility is actually put on the nurse. I still feel that often the nurse is the only one holding the bag, and you're standing alone.*

****

Nancy: *I think that if a man tells a man that he is having pain, whether it's the patient telling the doctor or the patient telling a male nurse, if he says it, because he's a man, he is believed more. The other thing is that, on the whole, women deal with the postoperative pain better than men; therefore women bounce back a lot quicker. I think that all comes down to the fact that most women throughout their lives have not been able to allow themselves the privilege of not bouncing back quickly. When you're a wife and mother and you're sick with the flu you can't go to bed for three days like your husband does. The house just doesn't work that way. So you have learned to cope with it, you have to get better quickly.*

My mom died of cancer. When she had the mastectomy, that was probably one of the worst things for her. It was a year before she had full range of motion again. That killed her because, she thought, "It's two weeks later; I should be back to normal." And she pushed herself.

You look at things like dysmenorrhoea. How many years were we told we just had to live with that - because women have always been told, when you have a little bit of pain, don't complain about it, don't do anything about it, just get on with it. And so I don't think women complain as much postoperatively as men do.

I think it's the same with the open heart surgery patients. You don't lay around in bed; you get moving and you get on with it. Our step down unit was like the third, fourth and fifth day post open hearts, but you'd go in and your female patient would be making the bed for you because she didn't want to sit down and see you working that hard. The male patient would be sitting there. I mean the biggest problem with the female patient was saying "Don't do these things, I'll take care of it!" The woman's likely just to kind of keep it to herself and keep on plugging.

Janet: *And I think that comes from women always being sort of servants. Even with my parents, my mother is 11 years younger than my father and yet she is always waiting on him. My father has always sat down and she served the meal. And if he wants his coffee halfway through the meal, she'd get up and interrupt her meal. And it's the same with nurses. We do everything to help our patient. It's getting less so with the physicians, but they still expect service so we have to serve them. I still see that in practice and it will be that way until we get more men into our nursing.*

Nancy: *Well, do we want our values to change! You know, part of that value is what makes nursing what it is. I mean there's been a lot of discussion about that. If more and more men get into nursing, what happens to the caring in nursing? Is it going to become more a business than a caring profession? When we attract different people we won't have*

> *that. I mean the "serving" part I could see go with no problem - but a certain amount of that serving is involved with the caring.*
>
> *I think things will change. Like it or not, nursing isn't listened to because it's a female profession and that, once you have male voices, it'll be listened to more. But I think we have to be careful of our balance, is all!*

Janet, Noella and Nancy have a rather extended conversation concerning their experiences around "caring". The passages give some feeling for their enthusiasm, ambivalence and dismay!

It is important to do the nitty gritty work of caring for people especially when they are sick, grieving or someone's loved one. Having a caring attitude is a tremendous positive challenge yet in day to day living, even with their significant others, care is misunderstood at best and scorned at worst. They understand the gendered construction of 'care' and are uncertain whether to increase nursing's status and credibility by incorporating male voices or if in some way we need to be careful of 'our balance'.

Images of gender emerge clearly in the patterns of themes throughout the narratives. One might inquire if this difference of gender was seen as an essential quality, that is, intrinsic to the nature of being a woman or were these traits seen as socially constituted and historically evolved. This may be an important question, but the nurses in this study were for the most part too busy trying to find a place to stand in the midst of these gendered images that they really did not address this issue. Their focus was on how to make sense of their gendered positions and choose a way to write their own script within that wider context.

Their struggle is reminiscent of Carolyn Heilbrun's (1990) description of how women imagine, invent and weave their own stories.

> We invent as we go along, support one another, and recognize, as we must, that our choice is as Florence Nightingale long ago told us, between pain and paralysis.

> One cannot make up stories; one can only retell in new ways the stories one has already heard. Let us agree in this; that we live our lives through texts (pp. 128, 129).

The Tension Between Representations of Self

There is a tension which arises between the various representations in several ways. The first is inherent in the very different foci on being and on caring represented in the orientations themselves. The image of self, characterized in the role of caretaker, as seen in the metaphors of the 'selfless' caring for others as mothers, daughters and wives. This is a duty to take care of, serve, be responsible for everyone. The second image of self is that of a person, a woman, being in relationship. It is a caring about, an attention to the detail of the other. It embodies qualities of responsiveness, mutuality and respect which keep the self very much interactive and involved in the ongoing process.

Figure 1 represents a preview of two collections of themes that illustrate possible representations of how we imagine ourselves to be as nurses. There is also a tension in the sense of the nurses being stretched in between the images. They rarely if ever live in 'one way of being' for any period of time. There is flux and there is an experience of being in both and neither; frequent descriptions allude to experiencing themselves "caught" in the spaces between. It is not hard to envision a tension or strained condition of mind, feelings and nerves. These tensions simultaneously offer dilemmas and possibilities.

As we travel through the next chapter it will become clearer how these images of ourselves permeate our relationships with patients, their families, colleagues, head nurses, and physicians. In each section there will be stories of how the nurse finds some of these problematic and discussions of what is troublesome in those relationships. There will also be stories alive with possibilities and an exploration of the qualities that are valued in other patterns of relationship.

The only way to bring these tensions to understanding in this text is to offer many descriptions of what life is like for the nurse in living

	Image of Self as Caretaker	Image of Self as a Being in Relationship
Main focus:	task/role	person/relational
Interactions:	hierarchical	egalitarian
Structure metaphor:	nuclear family	organic community
Patient metaphor:	as child	as friend
Nature of world:	secular, technological, material	sacred, humane, ineffable
Learning:	knows from experts	values knowing from experience
Guided by:	conforming to rules	conforming to ideal
Goal:	perfection in doing	to be in touch, in tune
Reward:	appreciation for doing	just being there
Self is:	instrumental	ontological, epistemological
Self is:	less important than actions	important as embedded in life
Ethics:	prescribed by rules, right/wrong	contextual, personal, fluid
Expectations:	to care for everyone	care about, attention to detail
Responsibility:	duty/blame	responsive to
Taking care:	control/support	respect, mutuality
Personal safety:	keeping proper place, distance, role	feeling of belonging in bigger matrix
Nursing:	takes energy - work	gives energy - joy/pain

Figure 1. The Tension Between Representations of Self

these relationships. A central tenet of this inquiry is that this knowledge is best gained through reflection in *'le quotidien'*, a focus on daily life.

The text presented here has already encountered circles of hermeneutic interpretation. The speaker telling her story is, as Heilbrun suggests, retelling in new ways the stories she has already heard. Specific narratives are called out because of the tone of the setting and participative listening of those sitting with her in conversation. The nurses sometime negotiate meanings and at other times make a *partage* or patchwork quilt of meanings.

As author of this research, I have exerted a strong interpretive influence on the final chorus of voices. Fewer than ten percent of the original conversations are reconstructed here in the text and they are rearranged from their spoken sequence. This act of editing is a powerful interpretive lens. The reflective comments (non-italics) interspersed with the nurses conversations are not intended to summarize their voices but to share with the reader my own ongoing reflective interpretation, inviting the reader to also join in the process. Each section of narrative and reflection is constructed with as much economy as I was able to manage. The intent of Chapter IV is that the elements or themes will be explicated and brought to life in the context of the present. The perplexing quandary of 'whose voice?' is represented in this text will also be addressed in the last chapter.

CHAPTER IV

STORIES AND REFLECTIONS ON RELATIONSHIP

Relationship with Patients and Their Families

We have come to wonder

What are the elements in the intensity of the feelings we have about our patients? What do we mean by "responsibility"? What is it like for a nurse to stand with patients in the midst of life and death? What is it like for each of us to live in the tension between the real self and the professional persona? How is this lived out with our patients?

Here are conversations that attempt to sort out these relationships with patients that form the central purpose of being nurses. The nurses are trying to clarify for themselves and for us what are the qualities of these experiences.

Through these stories the individual pieces of cloth that will form the patterns in the quilt of themes will be sewn into place. It was through the telling, listening to, and talking about these narratives of our lives that the constellations of themes emerged.

"Intensive" care

'Intensive' comes from the same root as tension (tendere-stretch, tend) and seems quite fitting as we speak of nurses caught in the 'stretch' of many passions. However, the ordinary meaning in the health care system refers to the intensive, concentrated direct observation and care given to patients in this specialized area of a hospital. The following descriptions of relationships describe the nurses understanding of intensity in the quality of these interactions. The nurses struggle with the fine line between the passions of caring, nurturing, condemnation, control and dependence. The 'I/thou' in these meetings is passionately central, for better or worse. It's all in a day's work to be an inmate in this emotional, physical bedlam.

Maureen: *We've had a lot of gunshot wounds in the last year and I remember one man had shot himself in front of his family.*

When he came in he'd been declared brain dead, and they approached the wife about organ donation. She said "That's the least that son of a bitch could do - is to help somebody else!" It was very hard because you knew what the family thought of him. He had beat his wife, beat his kids, and I was just so angry at him. Let alone shooting himself in front of his children! What a trauma he put those kids through!

Noella: *That reminds me, this one day there was a patient right across from the desk who was kind of a big fellow, kind of demanding. I had the patient just kitty-corner and I was watching him while his nurse went on coffee break, then she said to me, "You have to be careful." He abuses his wife and he was demanding to use the telephone to phone her to get him the hell out of there. And as soon as she told me he abused his wife, I came from a battered marriage - my first marriage - I could not go near him. It was like you're the scum of the earth. As long as you're breathing, that's all that matters to me. I don't care if you're in pain, I don't care if you're uncomfortable or anything. I was amazed at the reaction it had on me, that I didn't want to have. It was like there was a wall built there inside me, which amazed me, because this happened to me twenty years ago, It was a long time ago but it still was there, an amazing trigger. It was quite surprising.*

Janet: *I remember one patient in ICU who came in with a stab wound to his abdomen. He tried to kill himself by jumping onto a knife. I found it very hard because of the situation, to build up any sort of rapport with him. It was hard for me as a young person to go to this 45 year old man who supposedly had everything going for him but, for some reason or another, it wasn't enough, and this was his solution. I did my nursing care but I just couldn't go that extra step beyond to say,* *why? or how come? or what led you to this? There is something that I couldn't cope with. I still have that feeling to this day, cause it kind of just sticks there.*

And I wonder...

In these descriptions, we hear strong condemnations; *'scum of the earth', 'son of a bitch'* which are accompanied by feelings of almost violent revulsion. When the nurses want to *walk away, or can't go the extra step* they really are deeply involved with these individuals. Their reactions say that they wish they didn't feel so intensely because it's that attentiveness to the other that engenders the *anger, and feelings that* just *kind of stick there.*

This lack of rapport is troublesome for these nurses. On the one hand they wish they could respond to them as another human being but in each case some wall was constructed because that person was blameworthy. He had transgressed, and in some way deserved to be punished, to be treated in this distant way. In these situations there is great difficulty for the nurses to imagine an egalitarian relationship with these 'others', it is much easier to maintain these patients at the very bottom of the hierarchy.

Maureen: *One situation that happened to me when I worked on a neurology ward was with a lady who had ALS (a progressively debilitating disease). We'd had her for 14 months and she was on a ventilator. She was totally "with it" but was so weak she couldn't even lift her bottom off the bed. When the hospital decided to close our ward she was told that she would have to be transferred to another ward and get used to an all new set of nurses. She had said that she didn't want to go to another ward and didn't want new nurses looking after her. We'd even taken her home on passes with support of the ventilator and an RT and a nurse, just so she could go home and see her pets and be at home for a little while. Over the next few weeks, the doctor that was in charge of the ward that* *month, talked to her and talked to her family. They had decided that they would inject morphine and another drug, and wait until she would fall asleep and then take the ventilator off and she would die. It was very hard because I was very attached to this lady. I spent 12 hours with her on a regular basis and I knew her routine.*

They had come to the nurses, we had a big meeting to see how we all felt about it. Some of the nurses had said, "You are killing her, it's murder, how dare you do that!" Other people understood that this is what she wanted. She'd never go home. She'd never get better and she just didn't want to go on like that. It's very difficult. I'll never forget the day that I went in to say goodbye. She was such a brave woman and to have gone through everything she did go through. I think the worst thing was saying goodbye to her and like I started crying; she started crying. It was hard and it was hard going through this again and sometimes you just don't feel you can go through it too many times with too many people and that's why I feel I ought to distance myself once in a while.

Noella: *We just had a patient in our unit, that passed away two days ago and he was a CFer* (a person with cystic fibrosis), *and he had had a lung transplant and went back for a second lung transplant and didn't do all that well after the second one. This young fellow was tall and skinny, with kind of a congenial laugh - a fun kind of guy. But you saw that so rarely in our unit because if he was in the unit, he was usually intubated (a tube into the windpipe for breathing) and he was so sick. When he got just a little bit better, he hated the unit so much because he was in one of those little isolation rooms. And one day, the nurses just said, "Get angry!" So he told the doctor he wanted to be f'n transferred* *out of this room today! And that was it and he did get transferred. It was like, "Yes! yes! you* ***are there!*** *" But that was the only little window I saw of a normal human being reacting to life.*

Then he came back into the unit, because he was very sick again. We were looking for signs of any neurological deficit or if there was anything there at all. I would hold his hand, and say, "Squeeze my hand." There was just, after a moment, I could just barely feel his index finger, just quiver. Through the night he got to the point where he could open his eyes and look at me and he could nod his head. So I knew that he was still there but he had subcutaneous emphysema. His head was all distorted and he was trached and he was just, I don't know, to me, they are human but there's no personality to this person on the bed. That's how I usually deal with that. He had been called up for the second lung transplant while he was doing a movie about children who have CF and how they perceive life and just day to day living.

We watched this movie in the night and it was him sitting on the step talking with another girl who's a CFer. She's waiting for a lung transplant too and they had such a rapport. Then you see him roller blading down the road and he's out in the field and he's telling stupid little jokes. And he was real and it was so difficult and yet it was a relief to go back in and deal with him. When he started coming around, he was septic and he was bleeding into his abdomen something fierce, and you just knew he wasn't going to make it. But you are still going, yes, please try hard, please come back because I just really got to know you and I don't want to lose you now.

I went home that day, came back the next night and went to the back room and he was gone! They had turned him off *during the day and it was such a shock to me. They don't usually do that on our unit but this young man had a living will. But the thing that shocked me and caused my strong reaction was that I didn't get a chance to say goodbye to him. That bothered me more than anything else, I thought, damn it, why didn't they tell me. In the back of my mind, I'm hoping they don't put him through the torture, that we have seen other patients go through. But when they did it, kind of like, without telling me after I was so involved with this patient and then there was nothing! I didn't know if I was mad or relieved or what - It's just - he's gone, he's gone!*

Maureen: *I think you do have to take care of yourself. There is a line that I sometimes go over and sometimes I know that I just can't. I have other people depending on me to help them go through things. I still care about my patients, their families, and all they are going through but there is a certain line for me of getting very personally involved and really caring. I don't know if caring is the right word but getting involved with the family and stuff like that that I have to sometimes not cross or otherwise I'd just burn out.*

Nancy: *Maybe it's that it's not being personal enough? When I was in the States we did pre-op teaching for our open heart surgery patients. The patients and their families were given a tour of the ICU, so they'd know what they were going to be like the next day, so it would lessen the shock. During our history taking, we looked for personal items, like what were their hobbies. After you got the bed ready the next day, you made them cough pillows. On the one side it would say "Mr. so and so, hold me when you cough." On the other side, depending on the varying degrees of artistic ability, you drew things that reflected their hobbies, like if he fished, you'd draw a man fishing on a river.*

Even before you had them as patients, you had a personal rapport. It was hard when they died but I think there was an opening and a closure rather than just the middle part.

Maureen: *I agree that they need to be personalized but I still think that you are not their daughter or granddaughter. You know what I mean?*

Nancy: *Yes, I think you distance as you need to, but especially in the unit where often people's condition tends towards depersonalizing anyway. It gives you a little bit of help that this is a* *person* *lying there unconscious.*

Maureen: *I agree, we will quite often ask families of trauma victims to bring in pictures of what they looked like before instead of with head dressings and everything else.*

And I wonder...

Is getting personally involved, the blessing or the trauma? Clearly, these nurses see that being intensively engaged with patients as part of the care of their nursing. In these touching stories they tell us of the work, the joy and the pain of nursing care. Maureen was very attached to this brave woman, knew her and respected what she wanted but it was the most difficult thing she ever did, to say goodbye. Noella just really got to know this teenager as a person. She cheered him on and asked him please try hard. Come back, I don't want to lose you now! She was simultaneously shocked, angry and relieved when he was suddenly gone, and bothered because they didn't tell her even after she had gotten so involved. Nancy tells that it's important to develop a rapport by looking for personal items like hobbies to incorporate into their otherwise sterile environment, that it is hard when they die but at least there's an opening and a closure to the relationship.

(Heather talks about a long term ICU patient)

Heather: *I think everybody really liked her and really pulled for her and probably didn't blame her for trying to control the situation (the direction of her medical care). The nurses* *that were sort of her friends didn't feel that way whereas the ones who were just her caregivers may have sometimes thought that she probably tried to hold off being on a ventilator too long. But I mean it was her decision; it was her life!*

Ann: *What's the difference between friends and caregivers in that situation?*

Heather: *I think there is a difference. Most of the time I am a caregiver and this is one of the few times I've been a friend and I was only a friend because she was assigned to me so many times. I got to know her. I think you have a special feeling, you do a lot for your patients, but I think for friends, you go that much further. You do all sorts of little things. Maybe sitting with her a little longer than you would have sat with another patient. I think doing extra special little things, like washing her hair, you know, doing things like that. Maybe fighting the doctors a little harder about something more in terms of having her wishes acknowledged. If it was "just a patient", you might let the doctor know what the patient wanted but if he really didn't want to, you may not push as much as for a friend.*

Maureen: *I had worked on the floors for about five years before I went into the ICU and I just couldn't believe the control I had over the patients in the unit. I always saw what their heart rate was and their blood pressure. I felt that I knew the patient better and I really liked that about the intensive care unit. I knew all about the different systems and I just had more control over that patient. And when we were working on their chest we got the satisfaction of knowing that their blood gases are better the next time. I just felt you had more satisfaction during the day of seeing your patient in little ways get better and sometimes not get better but I think I liked the control.*

But in the Neurological Intensive Care there's a lot of going on that's all part of the day's work. A lot of our patients are confused, combative, aggressive, and violent. It's very common in my work that if I'm getting really, really ticked, I just keep telling myself, "It's his brain." You know, it's his brain and he doesn't know what he's doing, even after I've gotten kicked in the head a few times. We keep the majority of our patients restrained and give them sedation whenever we can. I just have to keep telling yourself, this isn't him! This is part of his sickness.

Well, there are times in our unit when we have five or six people that are trying to crawl out of bed. They are trying to sit up with all their endotubes, all their stuff, their chest tubes, everything, and trying to get out of bed. It gets kind of frustrating when you've got five or six of them on the go at one time. You get exhausted just looking at them. And we have them tied up all over the place. They're banging their casts all over and you have to laugh, otherwise you'd cry because they never look nice. They're all over the place, and you just do the best you can and try not to get too frustrated with them.

****

Nancy: *And sometimes caring also means making a person take responsibility. It isn't necessarily doing for them.*

Maureen: *Sometimes it's a lot easier if you do it for them.*

Nancy: *I remember having a stroke patient - we were saying to him that he had to dress himself that morning and he was getting mad at us and said, "That's what you are paid to do!" Our answer was, "No, we are paid to help you get better and if that means having you do it yourself, that's what that is!"*

Maureen: *It isn't that we don't care. It's like that saying that sometimes it's cruel to be kind. That is part of nursing too*

> *and sometimes it's painful to have the person do things but if that's what's needed to care, then you do it.*

And I wonder...

Many of the nurses shared Maureen's contention that "control" is a big advantage in intensive care nursing. However it seems control have several quite different shades of meaning. In this story we see a control that is not only having the power to direct an activity or outcome but the power of knowing on an intimate level. This applies to both the physical level of heart, blood and lungs but also an all-seeing vigilance where the nurse cares for and protects patients even from themselves. This position of powerful beneficence can take on qualities that are godlike, parental, or an intimate fellowship dependent upon the structure and interaction of the relationship.

Dilemma of response/ability

Nurses are responsible for coordinating and 'overseeing' as well as providing patient care. What does it mean to be able to respond? What are the boundaries of such responses?

Marie:

> *I think the most negative side of nursing for me is if a patient abuses me verbally. That's always upset me quite a bit, I still have negative feelings to deal with there. There was an incident, where the man had a recent heart attack and was also coming out of the DTs. He had done some boxing before in his past life. We had a restraint on him, but that was not sufficient because he was very strong. And there was a doctor and another nurse holding onto both sides of his restraint but he was still sitting on the side of the bed, just about out of the bed. The patient was tearing the restraint and I was in front of the guy trying to get his IV, to give him valium. He missed me by a little bit but not by much. He said he wanted to kill and he was always trying to reach for me and he said he knew exactly where to hit me to kill me. At the time I felt scared and I had feelings of anger too. Feelings of anger and feelings of not being able*

to help myself because this person was stronger than me and he was mistaking my care for negative care. I'd just like to turn my back and pretend the situation never existed - just walk away. Let some other nurse go on in there and take care of the patient.

Nurses frequently talked about the strong emotional responses that they encountered over issues involving responsibility. Here Marie felt scared because her life was in danger, angry because he was mistaking her intentions of care and yet she has no doubt that "some nurse will go in there and take care of the patient". Such are often the bounds and bonds of this responsibility!

Heather tells two stories now that help unravel the complex intertwinings of this response/ability.

Heather: *This one patient that comes to mind was a 32 year old banker who was grossly overweight and she had her stomach stapled. Her surgeons didn't really want to do it but she insisted because she wasn't progressing anywhere in the bank because, being so fat, they wouldn't promote her.*

She got terrible lung problems and also went into renal failure. She was extremely large and very difficult to turn and just had a lot of problems. For at least three months she was really very unstable. It was sort of a series of peaks and valleys and it almost got to the point where she was a non-entity.

I'll never forget, she was extubated and she was on a (oxygen) mask and they may have extubated her too soon. I remember she had slipped down in bed and she wanted to be moved up in bed and she really wasn't very responsive. I went to move her up in bed and she must have held her breath and she arrested. They intubated her and the respirologist knocked out her front tooth and we didn't know if she'd swallowed the tooth. We sort of went through another round of *her being really sick again. She started to seizure at one point, (I can't remember why) and she was dialysed. It was at that point where she was almost a non-entity because she was unconscious and despite everybody's hard efforts, she wasn't getting better. I mean it wasn't her fault but it was a very frustrating situation. I don't know why I called her a non-entity. It was just the feelings that she evoked. I've taken care of lots of other patients but it just seemed like it was a series of misfortunes that befell this poor woman.*

She had a mother who used to drive me up the wall. I mean, she was a very supportive mother! I think a little too supportive. Her mother used to talk to her and say, when she'd come home, she could sit on the porch and her mom would bring her milk shakes! I'd think she's *here* *because you were doing that! She did have a family but they were also the kind that threatened to sue or inferred that they would sue if anything went wrong. It was very hard to get close to her family.*

It was incredible because it got to a point where nobody really wanted to take care of her. I think because she'd been there for so long and wasn't doing anything. Then when she started to get better, she started to get better quickly. It really only took her about three weeks to go from needing people, to being able to turn herself and get out of bed. I can remember her getting up and walking around, after we had to fight for so many weeks to get her to do any sort of exercise! It got to a point where we almost had to slow her down. Then she was a really neat person; I *really* *liked her at the end and yet going through it, she didn't evoke positive feelings. It wasn't her size or anything, it was that she had sort of given up and didn't want to do anything and I guess that kind of made me mad which, I mean, if I were in her position, who knows what I would do?*

****

Heather: *I thought it was time to leave nursing because I would just live for my days off. I did not want to go to work. Once I was there, I hope I did my work well but I was not looking forward to going to work. Over the years I kind of felt I was giving more and more. I don't know if I was becoming more selfish or if I just had less and less to give.*

I was working in emergency on New Year's eve and it was three in the morning. The ambulance had brought this lady in who had been badly beaten up by her husband. The nine year old daughter had called the ambulance and come in with her. Her mother was living common law with a man that wasn't the girl's father. I mean it's okay, but he used to beat her up a lot. The story is kind of strange. She had gone to the bar and got drunk and some women had beaten her up and then she got home and her husband had beaten her.

The Admitting Clerk who was sitting with this nine year old daughter said she thought she had been drinking too. She was a very nice little girl - very tough and very street wise. She was telling us that she and her mom were trying to give up smoking and I just kind of thought, this poor kid, what a life she has! The mother was having X-rays, and I didn't know what was going to happen. This girl's real father lived in another city and her grandmother lived 200 miles away. I really couldn't send this child home to this man because I didn't know if he would be beating her up. So we called Victim's Assistance and they came in and sat with this little girl. Actually we had put her to bed for a while in a doctor's room.

Anyway, there was no damage to the mother - bruises but no serious damage. She was very drunk and was very pissed off at the doctor because he wouldn't give her anything for pain. He wouldn't because she was so drunk and he had said for her *to come back the next day to get pain killers. So she stormed around and went into the waiting room.*

She had no shoes because the ambulance didn't bring shoes or a jacket. We didn't have slippers in our hospital so I got her a couple of OR boots to put on. And the Victim's Assistance people had offered to drive her home. She had been swearing that she didn't want to go with them. I went over and asked her what was wrong. She said, "Nothing!". I said, "Well, these ladies have offered to take you home." "I don't want to go home with them". She was swearing and she didn't have her boots on and I said, "I'm sorry but that's all we have and at least they will keep your feet covered until you get home." She didn't want them! So I said, "Okay, you can sit there and rot for all I care" and walked away!

I thought, oh dear, I would never have said that a long time ago. There were other people in the waiting room and they were standing and staring at me. I was just fed up. We had had drunks in all night and I wasn't too impressed with this lady in the first place. Not that she had been beaten up or drunk, but it was just her whole attitude. I felt bad because she had been very rude to these Victim's Assistance people who were there just to help her. It was the middle of the night and they had wanted to go to bed and I had called them.

Anyway, her daughter came over later and said they'd accept the ride home with these people. I went to her and asked her if she was going to beat up her daughter when she got home, because the Victim's Assistance people were a little afraid that she was going to do something to her daughter. I'm not sure whether her daughter had said something. She said she wouldn't and we talked to the daughter. I mean we had no jurisdiction over her. It was the mother who had been

> *brought in, not the daughter as a patient. But we ended up by sending them both home.*
>
> *I just thought that I've really lost my milk of human kindness - I really got fed up. I really did not care. I was just extremely mad at her and why, what was there to be mad at her about? Because she was unfortunate enough to be in a stupid situation, a poor relationship! I really felt it would be nice to have a desk job away from people for a while and I could get refreshed and go back.*
>
> *It's very nice when people thank you. I guess it's an acknowledgement that you've been successful. That what you've tried to do has touched them in some way. I don't want to belittle people's thank yous, but if they don't say thank you, it's alright too. I still get my salary. I guess it is a frustration in not being able to do anything that can make a difference or has some positive effect on these people.*

And I wonder...

What is the difference in a sense of responsibility that has as its boundaries the duty to care for and the blame of failure versus a sense of responsibility in which an ability to respond to another is evoked?

How are the nurse and the patient bound to each other?

The earliest use of "bound" meant to be tied in the same bundle; to be intimately connected. Later, after the fourteenth century it came to also mean the setting of limits, to confine by a border. I sense that some of the nurses frustration is not knowing for sure whether the boundary with patients is holding them together or keeping them separate.

In the one situation patients are expected to respond to therapy (or die). They are to be appreciative to our care and efforts. They are to have the right attitude and be polite. Families are not to contribute to the patients illness and they are not to threaten lawsuits. Nurses are to work hard for patients. They are to coordinate care, call in extra services, care for children, find slippers and organize rides home and have unlimited patience. We each have duties and are held responsible or blamed if we don't do what's expected. There is a neat boundary between your role and mine and between duty and blame.

One could also read these situations in another way. The nurse considers the woman who had given up after a series of misfortunes and ponders "If I were in her position who knows what I would do?" She states clearly that her concern for the very tough and streetwise kid is not a matter of jurisdiction but the thought of "what a life she has!" and wanting to "touch them in some way that can make a difference". This boundary is very personal and contextual. It acknowledges being present to each other in a shared humanity.

When we are separated by a boundary and a tally is kept of that which is given, it is easy to see how one might feel they were giving more and more and becoming less and less. Perhaps the alternative to this is what Fox-Keller (1985) is referring to when she says

> that dynamic autonomy is a product at least as much of relatedness as it is of delineation ... (it) reflects a sense of self as both differentiated from and related to others and a sense of others as subjects...
>
> Where such flexibility in the boundaries between self and other can survive, the distinction between self interests and altruism begins to lose its sharpness (p. 100).

Is this one sense in which these nurses see their care as the ability to respond to another in this way?

Ann: *What about people who don't take responsibility for themselves?*

Marie: *The whole focus on the future for nurses is to encourage people to become responsible for themselves. Therefore as nurses we feel that the patients should start taking responsibility in wanting to know what their pills are and our explaining exactly what they are taking. But then it falls a bit short when you get a patient who is addicted to a drug. Then it changes - that's a whole new ball of wax and how do I deal with these people - that is the very frustrating part for* *me. How do I go on to treat them as I would want to be treated in such a position when I have a hard time seeing myself as addicted?*

Sue: *And I know anytime we've confronted someone with that problem it's a big uproar! It's never the person who says, "Yes, I do have a problem." It's always a real conflict and those are the kind of conflicts I don't want to be involved in personally. It's a lot easier to give them a shot of gravol and say, "Hope your headache goes away!" I really don't feel that's right - I really don't feel comfortable with that decision but I have done it - it gets rid of the problem.*

Marie: *Then my thought is, but what will I do here if I don't give it to them? Am I helping them out if I don't give it? Is it addressing the real problem? No, it's not. It's best to just treat them now and hopefully they will be referred to someone who can help them take care of the problem - help them to see themselves.*

Heather: *Because you think sometimes, is now the time to treat their addiction? Not if they are here with a heart attack.*

Sue: *As a nurse, I just don't always feel it's up to me to decide if this is the time to confront the patient. I wouldn't take that on without at least having a physician's agreement to do it.*

Marie: *But the hard part is to give them the medication. I go ahead and give it but it's difficult. It's just something that I have to.*

Heather: *You feel like you are supporting their habit.*

Sue: *If they don't get it from you, they would get it somewhere else. I would feel okay giving it to them if the problem could be addressed at the time. "I really believe you have a problem and you should deal with it." That would be something I would be more comfortable with doing, as opposed* *to giving it and pretending the problem wasn't there. I don't like that.*

Heather: *We were never taught to confront people in nursing school. It was always someone in authority confronted the patient, like the doctor.*

Sue: *Yeah, I don't think I would have the guts to do it.*

Heather: *I think individual personalities can do it. I think it's very difficult just to expect everybody to be able to say it diplomatically or therapeutically or correctly without sounding accusing or judgemental. We are not comfortable doing it, because I don't think we were ever taught or socialized how to be this way. Even with years of experience I find it very difficult to talk to people like that.*

****

Ann: *What do you think about telling patients things like medication errors?*

Marie: *I could see it's a big dilemma. I've had quite a few patients who've picked up their own medication error. "I didn't have this before." I don't think those patients have lost that much confidence in the nurses but I can see difficulty in telling the patient that an error has been made.*

Heather: *Should they be told? - yes. Are they told? - no, not usually. I guess it depends on what their medication is and if you are watching them to see if they've any adverse effects. I guess they should be told because they should know everything that's going on. It's sort of like informed consent - they should know what all the options are and what all the factors are. I have a philosophy where I try to nurse people as I'd like to be nursed. If somebody gave me the wrong medication, I feel I have the right to know.*

Sue: *I do too but if someone told me that they had given me double, next time they came near me I would probably lose my* *confidence just from one incident. It would be unjustified but because if it was me I would really lose confidence in them.*

Heather: *I was going to go on and say that, you know, it has another side - you are there defenceless, lying in bed thinking, oh my God, I've had twice the digoxin that I should! Not really knowing what digoxin does, they are sort of lying there like a time bomb waiting to go off. There is a lack of trust that results, I don't know! Most of my patients were unconscious, thank God!*

Sue: *I remember even telling the parents that I gave a double dose of antibiotics. That was really detrimental and their trust level was shattered after that. If they thought the day before their kid had got a double dose, they were really questioning what you were doing. Rightly so, but you kind of wonder. I think it's important they were told but law suits have come out of it and justifiably so. And the rapport between the staff and the parents was just the pits after that. Care would suffer, of course. It's kind of a vicious circle really. I see it as a real dilemma. I would like to know on the one hand but on the other hand, it's done!*

Heather: *Part of me says it's like lying to the patients when you don't tell them. But part of me thinks it causes a lot of problems if you tell them.*

And I wonder...

Why do we hear such agonizing confusion in trying to sort out who is responsible? for what? to whom? how should one respond? to whom? in what context? For these nurses the reciprocity between responsible and responsive take on the qualities of a hall of mirrors. Each action and/or attitude calls out the need to answer, to give a reply. The morally accountable response has a reciprocal pledge to be capable, reliable and trustworthy as well as sensitive and caring.

These interactions can be framed as an obligation if one is viewing the world from a hierarchical and principled perspective. They will appear as a call to be responsive in a more relational, egalitarian view of human existence. Both views are found to be helpful as well as problematic. The dilemma is compounded in that these nurses see themselves grounded in both traditions. Using the addiction scenario as an example the nurse is equally uncomfortable in confronting, supporting the habit and/or pretending it doesn't exist. She also finds it a challenge to imagine herself as addicted, or to always be diplomatic, therapeutic and nonjudgemental!

Dealing with the meaning of life and death

In the next two stories Marie tells of her relationships with two dying patients and their families. In the telling she sketches for us a vision of the world that is humane, sacred and at times difficult to put into words.

Marie: *Many of the people that I remember most are those I took care of for a while before they died. In paediatrics, I still remember this little girl who had a terrible liver problem and she was just a beautiful little thing. I used to call her Princess although that wasn't her name. I formed a relationship with her and then she passed away and death is alright. I find it totally acceptable. It's part of living; it's part of the continuation of life. If you believe in life after death, it's just a transition, one state to another.*

Princess was a dear child totally accepting of her illness, without complaints, except crying sometimes if she had pain. She was beautiful. Blonde hair and fine features. Long limbs. Big tummy but she was beautiful and you want to take care of people like her, you want to feed them and they try for you. They try and eat even though they don't want to eat. I think maybe it's their acceptance of everything - even of their imminent death, although they wouldn't be able to put *into words, that they will die. They're so innocent and so helpless. Her mom seemed resigned and was accepting the situation. I don't recall any anger towards doctors, or nurses for her child's illness. I can't remember conversations with her about death and dying. I was quite young then and might not have been able to approach it or discuss it very well.*

I think I can get in touch with patients in a different way now than when I was a young nurse because of my experience. I know the course of their illness. I am able sometimes to warn them of what might be coming. I am not afraid to talk about death and dying if they bring it up or we talk about their illness. It's just experience. I am aware of Kubler-Ross but I've never read her book. I've read some of her articles but its mainly experience and having to go through it time and time again.

****

I'll always remember of this one old man. His wife came in and she had end-stage cardiac disease. I had never met this lady before because she hadn't been in our unit. The doctors said she was a no code (meaning no resuscitation efforts). I admitted her and called her husband to let him know her state. He said that he couldn't come in and I thought, "Oh gee, she's dying. Why can't he come in!"

I sat with her during the night. She was in congestive heart failure, she was fighting to breathe - so she didn't talk very much at all. When I asked her if she wanted to see a pastor or priest, she just shook her head. It's just that I knew she was all by herself. I felt she was going through the transition of this life, dying. I didn't know what her belief system was either. That's why I asked her if she needed anything. She wasn't upset in her dying. She remained *calm through it all, seemed quite peaceful. I touched her and held her hand. When it was quiet, I also was praying beside her the best that I could, to make this easier for her. I think it was more of a spiritual companionship than physical one, but the physical was there.*

I sat beside her through the night so that she wouldn't be alone. In the morning around 7:00 o'clock, I noticed a man sitting out in the waiting room. I asked him who he was, and he said his name and it was her husband. He had come in by taxi and I knew when I saw him why he couldn't come in during the middle of the night. He was bent over. He was old and had these thick glasses that accentuate his eyes - you really, really saw his eyes.

I brought him in and his wife had just passed away a little while before that. I explained that she was very peaceful when she passed away. I remember holding onto his arm. I took him to the room. I stayed with him for a while but I felt he needed to be alone so I left while he stayed with his wife. There weren't a lot of words said. He kissed her on the forehead and then he sat down beside her all bent over, holding her hand. He wasn't crying but he looked defeated somehow. I think they may have dealt with the idea of death. I had the feeling that they knew that their time was near.

So he sat with her for a while holding her hand, side by side. Then he got up and come out and said "What do I do now?" I started explaining and then I'd never done this before, but I started crying. I couldn't even speak to the guy. Someone else took over and she started crying too and, so the third nurse came, explained things, took care of things. I've often wondered why this particular incident upset me a lot. Maybe it was his acceptance of her death but

I think also it was his helplessness. I just wanted to hug him and take care of him. Because his eyes were so accentuated with the glasses, you could see the pain in them so much. Some patients seem helpless somehow, and they seem like children. They seem innocent; they're not hard.

Ann: *You said that the second nurse who then came to help you explain also felt very touched with this situation and cried. Were you surprised at that?*

Marie: *I suppose a little bit. Maybe she was reacting to me or maybe she was reacting to that patient. We didn't talk about it afterwards, so I really don't know how she felt. Although it wasn't a verbal communication, I did feel that I wasn't the only one feeling that this was important.*

And I wonder...

What was the shared experience that eluded language but recognized the important poignancy of this situation? What is it like to resonate in the pain of our human condition that touches that part of us that is innocent, helpless and accepting as we stand dwarfed in the presence of the ineffably profound? Is it here that we are called to be not only a physical sojourner but a spiritual companion?

The next pages tell how difficult it is to stay present in this way with others during these transitions when the nurse is also being summoned to live in world obsessed with "cure" and driven by secular technology.

Marie: *I would like the patient to be able to die with dignity. I don't like to be expected to do something that is totally against what I feel is right - Like trying to prolong their life when I know in the end, it won't help! There should be a coming to terms of what has occurred so we just allow things to be and it's natural. Whereas so many times here because this is a research hospital, they do more heroic things. I've noticed that more and it is actually upsetting inside, in my being. When a person has three cardiac arrests in one night* *and we are still going at it, half an hour apart, and he's arrested twice before, a few weeks before, it's just a dead end. I think it's just the gung ho attitude, the doctors find it more difficult to accept what might be the end.*

Partly, it has a lot to do with the residents. They will order things to do as a last ditch effort to see if it works. I think they mean well, they want to give the patient the last chance. But for most of us nurses, and I think for some of the doctors too, we know how desperately they are clutching at this last straw.

****

Heather: *Well, sometimes I've done CPR on what I've considered a dead body and it's sort of seemed like an insult to the dead body. You're taking away any dignity. They managed to die quite peacefully without us and we are coming and jumping on their chest and blowing into them. Sometimes I think it seems like a waste of time, too. You know it's like the person you are talking about who'd arrested three times in one night and twice before. It's sort of useless to them. It's always practice for us but it's useless to them.*

I mean, if you want to try and get something positive, you can say at least we've had practice doing CPR. If you've never done chest compressions on a real person before, it'll give you an idea of how it feels.

Ann: *Do you have any conflicts around resuscitation? Is there a turmoil around that for you?*

Marie: *Sometimes here there is. Yeah, I feel "why do this?" but I tend to follow the physicians orders. I have this feeling that no matter what we do, if it's time for the patient to go, it will be his time so therefore no matter what the physicians do or try and do, they will not be successful at it. So therefore, I tend to follow their orders rather* *than create a scene. I guess the other day with this particular patient, there was a scene. I wasn't on that night but this nurse was yelling - kind of lost it a bit and was yelling at this doctor, "Why are you doing this?" "What purpose is this?" He got very upset with her and they had a major blow up and he won. He won, and she left the room crying. She felt she was being an advocate for the patient, the patient wouldn't want to die like this. He felt that the patient could live, if they could get his heart going and his kidneys fixed up. His creatinine was 700 and his potassium was 7. He felt that if they could overcome this crisis that he could be viable, that he could be salvaged. No matter what they did, they couldn't get him to stop coding. But there were bad feelings that came out of it in terms of this particular nurse and the doctor. I think it might continue on in their working relationships, which is too bad. My idea in that situation is just to do what he wanted us to do and know that the patient would probably not survive. In the end, medical science couldn't win there.*

Ann: *Do you ever feel positive or good about resuscitative procedures?*

Marie: *There was one experience where a patient was going for surgery that morning and low and behold if he didn't go into a ventricular tachycardia and lose consciousness. I did defibrillate him and he came back. Oh, it was wonderful! I just about hugged him! He said, "What happened?" I was so happy to tell him that his heart had stopped for a little bit but we got it back and "You are going to be okay."*

I knew that he had a good life ahead of him and that this was worth it. It wasn't end stage for him. He would go for his surgery, have his coronary artery by-pass surgery and come out of it okay because his heart was in good condition.

And I wonder...

How shall we perceive death? The idea of *coming to terms* collides with *desperate last straw attempts*. *Insulting the body* is incompatible with *passing in dignity*. Are the terms of *salvageability* and *advocacy* in the same language? It seems that they are, *if the patient comes out okay*; if not, it is a *no win* conflict.

These nurses are not against the technological blessings that modern western medicine has to bestow. However what seems to be paramount is that the world be balanced; the sacred with the secular, the humane with the technological, and the tangible with the ineffable.

Heather: *I think as the years have gone on, I've become more comfortable touching people. You sort of get a feeling from them when it's okay to touch them. When you first put your hand on their shoulder, if they seem to tense up or pull away a little bit or don't seem to give under it, then you just don't pursue it any more.*

I think I'm just trying to communicate a sense of sympathy or empathy. Depending on what the situation is, that they are not alone, that there's somebody there and I think it sort of opens the path. If you just touch somebody, it sort of opens channels if they want to talk to you. You are open to talking to them about things - you are just there for them because sometimes that's all you can do.

Marie: *I have the sense too when I touch if they accept it. Usually it's a body movement of some kind. I'll touch them on the upper arm as I say something and then I'll draw away. To me it lets them know somehow that we are in it together too. That I'm a person like they are. I am not sick right now but I can understand what it is that they might be going through.*

If a procedure is being done to a patient that is painful, I tend to hold their hand. Many times they will squeeze my hand because it is painful or they're a little bit *scared. Usually I'll give a hug to a family member and not to the patient and often it's after a patient has died.*

Recently I remember this woman came from up north, she was on a transplant list. Her daughter had come up with her. Her father wasn't there yet and I remembered her mother died very suddenly, about 12 minutes into my shift. The daughter was totally unprepared for this. She was violently ill several times, crying, choking and I remember hugging her, trying to get her to be alright. And this young girl sat with her mom until her dad arrived about two and a half hours later. She didn't want to leave her body. And so I stayed with her as long as I could. I would take care of my patients and would come back in and check on her but I think staying with her mom helped her to deal with it in the end.

Sue: *Touching is very powerful, but not everyone likes that either so I guess you have to read it and see. I remember a really positive experience I had had with the family. This man came into emergency. He'd had lung cancer for a number of years. He became really ill very very quickly. He had a cardiac arrest at home. He came into emergency and we decided not to do anything. I stayed with the family and we got close really quickly. They just stood close to me. They asked me a lot of questions. I was part of what they were experiencing so I felt like I could touch them. Like it felt okay to and when I did touch them, it was okay for me to do that for them. You know, I could hug them or whatever but, with other people, I don't know, you have to see.*

Heather: *But I know for myself, if I am in a situation which is extremely upsetting, unless I want to break down and cry, I don't want anybody to touch me. I am fine until somebody does and then I'm crying.*

I think asking people what they need is important, and it seems so simple. If somebody's coming in and sitting with a very ill family member or somebody who has died, I always ask them, do they want me to stay? Do they want me to call a friend or the pastor or whoever?

Sue: *I think that's excellent because I think nurses have really good intuition about that. I experienced that when my grandmother was in the hospital, the times that the nurses came in and out were really appropriate. They would stay for a while and I knew they had other things to do. There wasn't a lot they could do. They just really handled her death very well, very compassionately too. It wasn't just, "Oh, another death, how sad!"*

And I wonder...

How do we know what really matters in life?

The nurses' accounts tell of what it is like to be embedded in the existential struggles of life and death. For them, this is a very visceral organic world of mind and body. *Comfortable acceptance* teeter totters with *innocent helplessness*. Memories of *particular loss haunt* you after *particular closeness*. *Touching opens channels; to be there, for crying, not to be alone, for talking and to acknowledge* as person. These channels open a way to understanding; we can only learn this way of being with others through life experiences.

It seems the nurses would agree with Maurice Berman's (1989) central tenant in his book Coming to Our Senses.

> We have inherited a civilization in which the things that really matter in human life exist at the margin of our culture. What matters? ... Coming to our senses means sorting this out once and for all. It also means becoming embodied. And the two ultimately amount to the same thing (p. 324).

Relationships with Nursing Colleagues

We have come to wonder

What experiences of our lives together as nurses bring us joy and satisfaction? What is at the root of the pain and anguish we so often experience in interactions with colleagues? How are these patterns perpetuated? What are the implications in that most nurses are women? How might we imagine that any of these relationships might be different?

The following conversations will focus on how we experience our relationship with the nurses in whose company we spend over 2000 hours each year! It will become clear that for better and/or worse these intense interactions form the context of a nurse's professional life.

The first three sections will explore problematic areas of conformity, rivalry and insecurity. The next two will talk about experiences that describe a sense of mutual support and kinship. The final sections will describe how gender is experienced as being embedded in these nurses images of their lives together.

The violence of conformity

Marie: *A lot of people didn't like this particular person who works in our unit on a casual basis. They were always teasing her but this particular night, they took her in the staff room and tied her up and gagged her. It took a long time before a patient heard her call out for help and I'm not quite sure how she got untied. Somehow she did get free but she refused to work with that group of nurses again. The group did not see how malignant what they had done was until after the fact when they saw the damage they had done to her. Now a lot of them apologized to her but they were a bit surprised at her reaction. It amazes me that they were surprised about it. I did not see it happening. She came to my group when we came on the day shift. I heard it from her side and I did hear one girl apologize to her "I'm sorry, I didn't know we upset you so much".*

Well I had heard comments from people on how they had a difficult time coping with this girl. She was talkative. She had strong opinions about things. She didn't always agree with what they said and she would just say what was on her *mind. She had a different type of personality also. She's an unmarried lady. I see her as being an eccentric person. She spends no money and is very, very frugal. Her clothes are second hand and they are worn until they are breaking apart. She's a really smart person, incredibly smart. She didn't fit the norm in the way the rest of us do.*

I think it was her personality. I don't think it had anything to do with nursing. She had a loud voice. Sometimes her voice would carry into the rooms and she might be saying something about a patient that maybe the patient could hear. By the same token, I think she gave pretty good nursing care because she had a very good knowledge base and knew all of her technical skills very well and knew what the patient needed.

I've often thought about why they did that. I think maybe it started to be a joke that was carried too far and there was a little bit of anger involved in it. That's why it went on as far as it did and why they weren't aware of her responses to what they were doing. They just didn't want her around.

Heather: *It really is dreadful. Maybe it's extreme in one sense but maybe it's symbolic of things that happen more frequently that are not that dramatic but similar. They tied her up and they shut her up and they got her out of their way. (voices over in agreement) We do it in other ways by just ignoring these people. By not talking to people you don't like.*

Sue: *It's part of what goes on, yeah. If I was working next to someone I really liked, then it would be a wonderful shift; but if I was working next to someone where there was tension, I mean, you could feel that! Definitely, there is anger if someone isn't respectful of other people and has their own way of doing things. That would be one way of handling it, ignore them and talk to them when I have to. If it has to do with*

> *patient care or if I am on their coffee break, I'd be cordial but definitely that's how I would handle those situations. I would only reach out so many times and then I would just go about my business. There would be no win in it for me to keep reaching out if they didn't want to be friends with me.*

After their initial shock, the nurses make sense of this "dreadful" story of horizontal violence by telling how it is symbolic of what often occurs in less dramatic ways. Nurses have a difficult time coping with a colleague who has a different personality, had their own way of doing things or strong opinions that don't fit the norm. They shut her up and they got her out of their way.

How can we understand such anger and such aggressive behavior? This nurse's sins included: having strong opinions, didn't always agree with other nurses, would just say what was on her mind, was an unmarried lady, eccentric, and very frugal wearing second hand worn clothes. She is incredibly smart, gives good nursing care and knew what patients needed.

The literature of oppressed group behavior comes to mind when I hear these stories. Possibly these nurses are unable to revolt against (or maybe even name) oppressive systems that effect their lives as women and as nurses. Frustration and aggression are vented through conflict within the group. It is interesting that this victim's transgressions were decidedly unfeminine characteristics - she was not conforming to the normative rules.

Brutality of One-up-man-ship

Janet: *When I was new to this particular unit, I found it was very hard to break the ice with a lot of people. They have their own little group and their own little cliques and as a new-comer, you weren't really welcomed with open arms. You had to pay your dues and crawl up the ladder before you were totally accepted. I found there were certain individuals that were quite assertive, more than I was accustomed to.*

Just little things, like when you suction, you always suction with two people and so when I would call upon this certain individual, she would say, well, "Don't you have everything ready yet!" "Well we usually do this, this, this before we suction!" "Have you done it?" It's like a constant checking and yet because you are new, you are still scrambling, trying to find things, trying to fit into the routine. I always felt I was three steps behind everyone else and they would make little comments like, "When are you going to get your act together"! And it's like, "I didn't know my act was missing!"

One example, was my first night and I was buddied with a very hyper nurse and the patient arrested three times and was sent back to the OR for bleeding. On the third code, I remember just being so stunned. There was just too much stimuli coming at me at once, I couldn't remember where to find things. I stood there like a bump on a log thinking, "How can I unglue my legs so that I can either get out of the way or go and get something?" But I was too scared to unglue in case someone expected me to respond to something. I remember someone shoving the code sheet in front of me, saying that I could be the recorder and thinking this is unfamiliar too. So I remember grabbing a piece of paper towel and starting to write things down and thinking, "Oh my god, what am I doing here! Have I made the wrong choice?" Maybe there was just too much! After the patient had gone to the OR, I remember the resident. He was quite an arrogant fellow from what I'd heard, say, "Well, who is she and what is she doing here!" I just thought, "Oh my God, what a moron I am!"

I was like in a state of shock. I heard it from a distance and it never really penetrated until after the whole shift had gone by. I always thought that was so inappropriate

> *to make me feel belittled. At work, I tried to maintain sort of this outer person so no one would really know how afraid or how frightened I was of a situation and then once I was beyond those doors of the hospital and in my car driving home, the tears would just roll down my face. I didn't sleep regularly or soundly for months while I was in that dilemma period. I really didn't feel close enough to any of my co-workers to let them know. I felt totally embarrassed. I was just overwhelmed by anything because this particularly aggressive person was always around. I felt uncomfortable for about four or five months. By the time I got to the sixth month, it was like a breaking point.*

Janet tells a story that was retold by many nurses, referring to different times and a variety of settings. Most nurses have been put down, embarrassed, and brought to tears by co-workers, often to the point of wondering if they should continue their work in nursing.

The nurses speak of a pernicious insecurity that feeds on the least experienced and often most vulnerable members. Is it the infamous "low self esteem" that is often ascribed to individuals who are in the nursing profession? Do some nurses strive to be slightly higher on the pecking order by practicing a brutal one-up-man-ship? If one lives by a personal orientation whose goal is a perfection in doing things beyond reproach, it would follow that another's feelings are less important than the faultlessness of their performance.

Protecting territory

Noella: *When I'm designated as team leader I don't want the other nurses to think that I am their boss. I want them to think of me as a team mate. I certainly don't know everything. I've only been there three years and besides they might know something about their patient that I don't know. Well, actually in this one situation that came up, this patient's MAP (blood pressure) was 110 when I first went into* *the room. The nurses were changing drips (IV medications) and this lady was very dependent on her drips and her blood pressure dropped. But the nurse was kind of in behind this bank of pumps and couldn't see the monitor and the pressure was like 47→45→41 and I stepped in and I increased the dopamine wide open until we got the blood pressure back. When we got a blood pressure, I turned it back to normal and I left her with a MAP of 74 and I said, "This is what I've done, you come in now and finish up," and I felt I was doing the right thing. About 10 minutes later, I heard this all the way down the unit, "You fucking near killed my patient! I have to give her morphine, now, because the blood pressure is so high!" It was very difficult to talk with that nurse after that. I went back and said to her, "Is there a problem? Let's talk about it." She was very upset and told me that I was a young nurse, a junior nurse who didn't know anything and I shouldn't stick my nose in! That she had heard lots of complaints from other people about me butting in when I was in charge. It really floored me because I've never had anybody tell me that I was always digging into their stuff! I just felt that I was in charge. It was my duty when the blood pressure dropped to below a life sustaining level that I should maybe step in because she wasn't there. There was a lot of confusion going on.*

Ann: *And in other words, you felt you were being scapegoated because you were interfering with her patient.*

Noella: *Oh definitely. Definitely! I was stepping out of bounds.*

Ann: *Do you have any interpretation of that?*

Noella: *Yeah, I do. I have quite large one but it's not a bitter thing. I always feel like I put myself in her shoes and I think at the time, her mother was severely ill and she* *was concerned about whether she was going to live or die. She doesn't have a lot of patience. I find for myself that raising three kids gives me a tremendous amount of patience and different ways of looking at things. She's very focused on only one thing and this is the way she sees things and there's no changing. She can't adapt; she can't change. She sees herself basically as a super nurse who does not need any help. I think that is very dangerous so I just look at all those things and I've tried to open communications with her again. I talk to her about general things now and don't deal with her patients. In fact, something happened shortly after that. She was helping receive another patient from the OR. Her patient was in the bed next to mine. I just went up and said, "Can I help?" Then, over her shoulder, she said, "You can do the vital signs on my patient." So I went over and the MAP was very low. It was like 52 and I thought I'm not changing a thing! I just called over and I said, "Your blood pressure is 52! Do you want me to do anything?" She looked around and said, "Well I'm busy here. Can't you fix it?" It was like, well I've got permission now to do it and that seemed to be okay. She kind of opened up a little bit after that but still there's a large barrier between us. I could be sitting there in front of her and she will look at the light switch instead. It's like she doesn't want to talk to me and then at other times, she surprises me because she will say something very personal.*

Janet: *I find too that ICU nurses are so protective, like this is their patient and they are very territorial. I find that even coming out in myself sometimes and I kind of step back and think, "Oh my God, what am I doing?"*

Is this rivalry another response to the insecurity we encountered in the last section? This may be a version played out by more seasoned nurses. There is a safety in protecting your territory and projecting an image of a super nurse who doesn't need any help. If the system rewards by an appreciation of how well one does then it makes sense not to let others 'stick their nose in your stuff'!

Noella has an interesting response. She turns her focus from the activities and considers the personal context of the individual and 'tries to open communications with her again'. She measures the degree of "openness or barrier" between them by the quality of their personal dialogue.

The next narratives tell what the experience is like when the barriers are down.

An organic community

Nancy: *You see, my experience is totally different. Mine is that we were a team and I might have been the nurse taking care of that patient but that it was everybody's patient. If your patient was relatively stable or if your patient was transferred out, you automatically went in and started helping with somebody else's care. If you notice something about their patient, you would say, "Oh, did you see that?" and in a case where you are changing IV's and the pressure dropped, it would be assumed that you would go in and take care of it. In fact, the ridicule would come from not doing it rather than for doing it.*

Sue: *We had this little boy Tommy for months and months. Everybody loved him. He was a beautiful little baby and just a real personality and he had a lot of bowel surgery and was really having trouble and he was finally starting to come along. One night, he just went brady (a slow heart rate) and everyone was just horrified! He had just run out of IV lines. He had no suitable veins left to start an IV. We were just horrified. We didn't know what we'd do because all of us felt a great attachment to this child. Finally, a very senior person came over and found this little capillary he had and we* *gave him some Atropine and he eventually stabilized. But I just remember how I felt when that was going on and how very much I relied on other people. I was just so relieved that there was one of us that had that skill to do it. It just felt so wonderful and you know, every time I see that woman, I just think, "You saved his life!"*

Nancy also understands there is an expected conformity in certain behaviors but in this case "the ridicule would come from not doing it..." One assumes that in a team, a mutual respectfulness is the ideal. Sue feels wonderful every time she sees her colleague because she can rely on her - "that one of us can do it!" There is a sense of security in belonging in a larger matrix. What is important is 'being there', embedded in life - in an organic community.

The inheritance

Nancy: *I worked with a group of nurses that were very close, to the point, when things went bad, you could say things to your colleagues. I can remember one Christmas morning, I had been on Christmas Eve and it had been, "ICU from hell night!" The day staff came on, bright and cheery, and said, "Merry Christmas!" and I said, "Yeah Merry fucking Christmas!" and when I got home, felt bad. I thought, "It's Christmas day, you greeted them like that!" I went back that night at seven and they said, "You were right!" But we could talk to each other and you knew that if it was a bad night you could say, "I can't take this any more. I've got to get out of the unit for a while" and we'd find a way.*

I think a lot of it had to do with the relationship between each other. Like after nights, if we went out, the whole team would go out for breakfast. I can remember one time, I was off but I phoned in on nights and they said, "Oh, we are going to meet at so and so's house tomorrow for breakfast. Why don't you get up and join us?" So I went and

> *I think at five o'clock when her husband came home, we were still there drinking wine. (Laughter) I mean, these were people I worked with but we knew each other very well and I think that has quite a bit to do with it.*
>
> *Another part of being a little gentler with people was just kind of a staff "awareness". I remembered things like when we were short staffed and had to bring relief nurses in, we sat down and thought, "Okay, which patients are going to be least threatening for them?" We had a realization that this is a very foreign, a very intimidating environment and so for relief people to be thrown in there without any training had to have been overwhelming. Therefore, we'd say, "Which ones can they take care of with the least help from us?" because also we were understaffed and that's when you don't have the time to give the help. As a result, we ended up having people who didn't mind coming to our unit because they knew an attempt would be made to take care of them.*
>
> *I think that it goes back to how you were brought into the unit. It's just like the student nurses. You have some floors that treat student nurses badly and often those are the nurses who as student nurses got treated badly. They never made a conscious decision when they were being treated badly to say, "I will never treat a student like that." You still have student nurses saying that on some units they are treated like dirt and I think it's a learned process.*

Nancy tells that when the nurses knew each other very well they can ask for, give and receive the support needed for difficult times. This was not only offered to the team but to strangers who came in to do relief work.

She goes on to suggest a larger parallel. We learn to nurture and respect others by being cared for and that there is a danger that unless we make a conscious effort to do otherwise, we will treat others like dirt if we were treated badly.

These narratives of relationships with our colleagues tell of what it is like to be sisters. The important question seems to be: what do we inherit in the family legacy of nursing? Is it insecurity, abuse, sibling rivalry as lesser children of a patriarchal, task-oriented system or is it a sense of kinship and support from a community with more humane relational values?

Perceptions of gender difference

However it is more complex than that, there are some powerful beliefs and experiences concerning gender differences in our lives as nurses. These become clearer in the following accounts.

Heather: *There were two male nurses working in the unit and one complained that the nurses were unfair to him. People were complaining about him and he thought it was just because he was a male. I like to think that they were critical of him because he wasn't very good - he was a very good technical nurse but he didn't do the caring things with the patients. He'd leave the patient's unit in a mess for the next nurse who was coming on. We didn't feel that he was turning his patients enough or giving them good enough mouth care or just the tender loving care things; however, he was technically very good.*

Sue: *We had one male nurse for a while out of 100 women and he was the kind of person, if you met him once you 'd know who he was the next time - that kind of person and he didn't get along that well in the unit. I personally never worked with him in my rotation but I socialized with him a bit. The nurses were upset because of similar things, like he'd put a baby to bed with a wet diaper whereas most of us just didn't do that. We always put them to bed neat, dry and comfortable. He just didn't think to do stuff like that. Partly he was in a world that was all women. People kept saying, "I wonder why he's here. I wonder why he'd want to work in neonatal* *intensive care?" They would really question why he was there and they thought it was very odd.*

Heather: *"Male's aren't nurturing."*

Sue: *He was a very normal guy, like he wasn't gay. He was not twisted or anything; he was a pretty decent human being actually - probably liked babies! I think for him a lot was the challenge of it - neonatal intensive care! I think he was interested in that and that's where he started. He didn't stay long. He moved on to another intensive care, probably because it was more acceptable to work in another area.*

Heather: *I always got the impression that the males that I've worked with were there to do the best job they could but I always got the feeling that it was a stepping stone to go somewhere else. That they weren't going to stay there for a long time. I think that nurses tend to be very giving and very nurturing and want to do everything for their patients and I don't think men are like that. I mean, just my experience with men in life - like putting the baby to bed with a wet diaper - it was not such a horrendous thing that he did. He just probably just never thought about it.*

Sue: *No, he never even thought about it but if you work in the neonatal intensive care, that's one thing you don't do - you don't put your baby to bed wet!*

Marie: *I haven't worked with a lot of men but I do feel that they are not as attentive to detail as women. I mean the details that add a lot to the comfort of the patients and add a lot to the comfort of the other nurses that you work with. It's not as important to them. They just don't see it. I don't want to say it's a defect. It's just that they have a different set of values and I cannot think like they do.*

Heather: *Nursing care has to do with intuition and yet medicine is a science - usually cold hard facts. Intuition is only a* *woman's intuition and I think male nurses can have that same intuition when they reach a certain level but I've never seen one who stayed in one place long enough to do it!*

Marie: *And I think that they are more goal orientated and these places are a stepping stone to something higher where they can make a bit more money and where they can have more control in the administration. I think it would be hard to work with a group of women. You might have a wife and you can have control of her but working with a group of women you have less control. Men are stronger mentally and they certainly don't have to conform; that's the male mentality.*

Heather: *I've worked with males and I've been a team leader or the charge nurse and you can feel this. I try to be very diplomatic, with everybody. I like to suggest that perhaps it would be a very good idea if they did this or that. I mean I can feel the sense of resentment, which is probably fairly natural. Not right, but fairly natural because generally they are the ones who are in control of as you say with their wives or whatever.*

Sue: *But there's that confidence. I like that confidence in a colleague so I do like working with men.*

This conversation indicates that these nurses have some very congruent ideas about gendered roles and how these affect them as nurses. Male traits include: not giving in a tender loving way, not attending to details that provide comfort for others, not intuitive, not being committed to giving service to others. However these nurses carefully say it is not a defect - simply different values. The males are naturally: technically good, more goal oriented toward administration, are stronger mentally and used to being in control. Before we are tempted to dismiss these accounts as naive stereotypical cliches it may be well to ask how do these very gendered role perceptions exist. That is the subject of the next conversation.

Wondering about socialization

Heather: *I remember this one male nurse. People didn't like working with him but that socially we got on. The general consensus of all the nurses was that he didn't pull his weight in terms of helping other people. If you asked, he would come and help but you always had to ask him all the time. We turn our patients every two hours. I went over and helped other nurses and they came over and helped me. It was very much a helping back and forth. If somebody had had a particular busy shift, then you went and emptied all their bottles and cleaned out their suction bottles, dumped their urine bags, did the cleaning up stuff. He didn't do this sort of thing and he tended not to turn his patients as much as everybody else.*

Sue: *Again it's the informal rules. That's the way we do it! I was just thinking about how we are socialized. I perceive that men, when they have a problem with each other in a business place, go up and say, "Please have your room cleaned next time!" Whereas a woman would probably say at coffee break, "This place was a mess. I guess I can clean it up but I just wish she'd put her coffee cup in the dishwasher". I wonder why it's so different.*

Heather: *I wonder if part of it is you don't want to hurt their feelings. I mean, it's hard to confront somebody; you're afraid you are going to hurt their feelings. You are sort of making yourself open - sort of a vulnerable thing.*

Marie: *Well, you are vulnerable too. Maybe they will retaliate and say, "Yeah, you do this!" Also I am wondering if it's an unconscious thing because you are supposed to put up with things. I mean, you are not supposed to complain. You are supposed to put up with other people's foibles. First of all, you worry, "Am I treading on their personality?" We raise children like that. We don't want to flaw their personality* *or make it too traumatic as they grow up. You don't want to step on them, or hurt them or damage their personality. The other thing that we were taught is you take it and you fix it. I'll just go ahead and fix it myself but I think if you are going to do that, you have to be willing not to complain about it. Pick up after everybody but if you want to complain about it, then you should learn to confront the people that have done that to you.*

Marie: *I find sometimes men are less tolerant of each other. They are not willing to put up with others, so they'll confront a person, ... maybe that's how big wars have started! (laughter) Women don't like wars and confrontations. Because they have children, they have a different perspective. If women were in political power, I wonder if we would talk more but we would also have to stop backbiting. I've seen that women do that consistently.*

As the nurses wonder about the differences in how men and women relate to others they conclude it has to do with the informal, possibly unconscious rules we live by. There is a difference in how we are taught to respond: men confront others, women do not. This avoidance of confrontation has to do with vulnerability both because we don't want to hurt others (like children) and also because of fear of retaliation. Also there is an expectation that women will just "take it "and "fix it". In the end Marie ponders whether the price we pay is trading aggressive behaviors for passive/aggressive ones.

Responses to male behaviors

Maureen: *It's interesting watching male nurses, isn't it? We have one in our unit and when the doctors come on rounds, he's like their buddy. We just sit back and we just watch him. It's a very different relationship he has with the doctors than we do.*

Noella: *Well, even our orderly has a much closer relationship with our doctors. Mainly because they are both the same.*

They are both Puerto Rican but you get those two together and they talk about women, about patients, about everything. I wish I had that rapport with this doctor that I could be so casual. They get into their own language and you just think, "It's the 'male bonding thing' but it is very interesting."

I think there are a few men in our unit that don't like to receive orders from women. It's like, you are almost telling him what to do if you suggest anything and he becomes very abrupt and you wonder whether it's burnout or what.

Maureen: *Bob, a nurse in our unit, is really a very humorous person so he does a lot of joking around and stuff. But there're things that he will ask the doctors for, and, they say, "Oh yeah, yeah, no problem!" But the day before, one of us had asked him and "No, no, we'll just wait on that!" He just seems to have a good old boy relationship and they'll do whatever he suggests, you know. It's quite funny. We sit and laugh about it but there are times that it is frustrating.*

Noella: *Nurses probably view a male nurse as kind of like an equal or not even as good because they are male and they don't have the mothering instinct or the caring instinct. But patients view them as doctors and doctors view them as an equal because they are also male.*

Nancy: *We had fun training the foreign doctors who felt they would sit around and didn't clean up after themselves because in their country, nurses just do all that.*

Noella: *Yes, or nurses who didn't stand up when they walked into the room and didn't address them as Dr. so and so. We called them by their first name and usually abbreviated it.*

Nancy: *They used to get taken back quite a while.*

Here are several responses to "male behavior". It is interesting and even funny when "male bonding" leads to a privileged rapport that so blatantly leads to preferential treatment. It is frustrating not to be heard, not respected as competent or expected to clean up after males because they are men. The nurses speak of resistance that they engaged in "training" against expectations of a privileged status.

Relationship with Head Nurses/Nursing Management

We have come to wonder

What are some of the qualities experienced in staff nurse/manager interactions? How do we make sense of the difficulties in these responses? What is the cost due to tensions in these relationships? How can we imagine this being otherwise?

The symbolic structure of the nuclear family often stands out in these nurses stories of their hopes, expectations and disappointments related to their head nurses and supervisors. It is interesting that all narratives were about first line managers - at least in these nurses accounts there is a void above that level.

The image of head nurse as "mother" takes on an almost hyperreality which is a quest for an artificial reality that surpasses the "everydayness" of our experience and give us a version that is "bigger and better than life". Borgmann (1992) describes three characteristic features of hyperreality: first, a brilliance that entirely engages the senses; second, a richness, or encyclopedic completeness; and third, a pliability entirely subject to ones desire and manipulation. "The telos of hyperreal logic would be a perfectly glamorous simulator" (p. 88). In this example the perfect image of mother is totally in tune to our senses, completely competent to "mother all" and entirely focused on meeting our every need. "This [new reality] conforms more fully to the ...promise of liberation from the recalcitrance of things, the confusion of circumstances, and the foibles of human beings" (Borgmann, 1992, p. 83). Possibly, it is that our need is such we pretend too much. It is understandable that we wish to imagine ourselves in a situation liberated from abandonment, betrayal and helplessness. The following narratives describe that struggle. The first two sections describe common interactions with unit managers; the third section, the consequences of these relationships, and finally how it might be otherwise.

Abandoned

Noella: *There was an episode with this physician's assistant. He'd been there for years and he usually was very supportive. He was notorious about making an awful mess when he pulls out chest tubes, like they just whoosh and there's blood everywhere. He doesn't like to wait so you can give the patient a little bit of analgesic, so the nurses tried to get him to be a little bit more patient. But this one particular day, the patient had the analgesic and he was getting all ready to get in there and the nurse, who's quite easy going and funny and competent, said, "Just wait, I'll put some blue pads down because the bed was just freshly made." He's going, "Oh, you don't have to do that" and she's going, "Yes, yes." And she stood in front of him between the patient and him and was going to put the blue pad on the bed. He just exploded, he just started yelling, "Get her out of here! Get her out of here! She's incompetent!" Then he just threw down his stuff and said, "Let me talk to our unit supervisor. Get her in here right now!" It was just like, God what happened to him! Has he flipped out? It was reported to the head nurse right away that the nurse had really acted out of line. It just floored me because instead of the head nurse going to him immediately which I thought she should have done, she said, "We'll give him a week or two to calm down, then I'll talk to him." Then the nurse was asked to apologize to him. It was automatically her fault, you know, without having questioned it or anything. It was blamed on "the nurse" and there was no backup and that kind of scenario was repeated time and time again in our unit. It's never the doctors or anybody else's fault. It's always the nurse. Whether you are right or wrong. There's not a lot of support.*

Janet: *We had a situation where medical rounds were always started at six a.m. and about a month ago, these rounds were beginning to start at 6:30, quarter to seven. We were caught in the midst of trying to give a report to the physicians and give reports to our co-worker at shift change. We were trying to accommodate people, finish our charting. Everybody was being dragged way behind. When we had our unit meetings, I discussed this with our supervisor and she said, "All you have to do is be more assertive." I said, "So if I tell the doctors that, at six-thirty, I'm not going to be able to accommodate the report." I hand them my flow sheet and say, "You read it, I don't have time", are you going to back me up? She said yes, but if I hadn't asked her that, there would be no back up because you can't rely on this particular person to support you. You are standing alone and that's it! She makes that very clear because she doesn't want to become involved with the members of her unit. But when it comes to the head nurse listening to us, either we are not talking in her terms or we are not catching her interest. Something is lacking when you get a deaf ear. I just find this so frustrating because she puts up the blockades. They talk about team work but it's not reinforced and she doesn't motivate her people. Once we acquire certain skills, where do we go from here? It's like, your nursing is at a dead end. I wish she could be involved in a Dale Carnegie course where it's like a self improvement, not for yourself but for others. Then she could motivate others and turn a negative situation around to make it positive.*

Noella: *Our head nurse doesn't want to go against the doctors, that was my feelings. She was there to keep them happy, not to keep us happy.*

Janet: *But I find it very hard to really feel that she's there for us, to see that she's really sincere and genuine in her interest in us as staff nurses.*

Noella: *But maybe that's just her way. She is a very aloof kind of person. I don't know. I always try to think that there's got to be another reason. It can't be because she doesn't like us. After all we are so likable! (Laughter)*

Nancy: *The first unit I worked in, I won't say the head nurse wasn't supportive. There was just no power in nursing. So she was supportive of us but the doctors still kind of had free rein. If you have managers who are just not assertive themselves, it's easier for them to put the nurses off than to fight the guy upstairs.*

Heather: *In the last unit I worked in, we had a head nurse that didn't do anything so she really wasn't a head nurse in terms of being a leader. She was a head nurse in terms of being a figurehead but so was the assistant head nurse. They were useless because I don't think either of them have their hearts in the job and I think that they probably got the jobs because they were the type of people who didn't challenge rules so that administration had nice malleable little people who would work better and do what they were bidden. It put more of a load on the other nurses and whoever were permanent team leaders to support the other staff. We didn't really respect these people. We didn't feel we had any backing from these people and it was probably one of the reasons why I left that intensive care.*

In this conversation, Noella, Janet, Nancy and Heather lament the lack of personal and professional support from their nurse managers. However it is clear that they expect more; they are deeply troubled that head nurses are so useless and unfit. They might dream of a Boadicea - head nurse (a first century female warrior queen of Britain) who would defend and not abandon, who would be loyal and not betray, who would be powerful and not cowardly. They feel they are on their own, without a leader without anyone to care about them or their work.

Sue now describes how many nurses feel when trying to respond to these situations.

Powerless

Sue: *I've gone to the head nurses of emergency several times and asked "Why can't the charts be close to the patient's bed?" As nurses we should be documenting more things. But it's kept at the desk by the physician. It makes it more difficult to get access to it. The time you spend travelling to get the chart could be better used doing other things or else you don't document. Basically that's what it comes down to. The documentation is very poor, very sparse. I mean coming from an ICU area to down there, I loved not having to do all that charting but I wonder sometimes if more charting shouldn't be done. It was comical the head nurse just said, "This is the way it is; you know the doctors. If we took their charts away, they wouldn't be real happy!"*

I never pursued it! I just felt it was a lost cause and sometimes you have to move on to other places because some places don't change. I've never come up against a supervisor where I've really clashed with them. I wouldn't do that because I wouldn't win. It would just be something that would probably frighten me and it wouldn't be worth it for me; to do that. My past experience tells me that what I say isn't going to have that much influence. It's kind of a chicken way out but that's really how I felt. I think nurses traditionally have felt that way and that has stopped us from doing a lot of things.

In my personal life, I think I'm pretty effective in conflict resolution because it's important to me but in my *professional life, it's not been something I've been real involved with. I'm a little bit leery about people who are creating problems all over the place and crisis. I think you have to have pretty strong reasons why you want things to change. You have to be willing to follow through on them and I'd have to be pretty committed to something to do that.*

For instance, I remember another time, approaching a head nurse in emergency about something else. We have a lot of people who come in who are suicidal and I don't think we deal with it that well. I had attended a lecture by the provincial suicidologist who spoke about how poor the emergency systems were and I talked to him a little bit. I said I would be the first to agree there are obviously some problems. He would have been willing to come to the emergency department and talk to us. That would be the first step toward making things better. I felt really excited about it and saw it as a real challenge! I went and talked to this woman, she goes, "What are you so excited about?" I felt like I was a little child and it was my mother and she wasn't allowing me to be happy. I thought, why did I even go to her in the first place! She's not the appropriate channel to go to even though she was the head nurse. This woman doesn't allow herself to feel happiness, so why would she allow me to feel happiness? That emotion bugs her.

I ended up going to the clinical development nurse. I didn't get her as excited as I was but she did get excited and she actually did try to get hold of this man. Nothing ever became of it and I didn't pursue it any more myself but I just kind of got really excited that maybe we can be more effective in doing this. Maybe it can start at the staff nurse level but I just remember thinking, after I had talked to her, "Why did I think it would be any different from this anyway?

Nothing else has changed her for so long, why would I be able to do it myself?" I'm not even willing to deal with those things in my life any more. I would rather work in an area where I can make a difference with people who are on the same wave length. We get feedback when something doesn't go right. When something goes wrong, that's when someone would notice. Otherwise I could do an excellent job and that would not be acknowledged.

Heather: *I think we magnify the life threatening effects of what we do. I mean there are certain things we do that do have serious consequences but in terms of some of the little things that we worry about, they may not be life threatening. Take for instance, making a medication mistake which in the total scheme of things may not be horrendous.*

Sue: *Yes, you have to sign an incident report and it sits in the middle of a desk and everyone flips it over and reads it. So all those things are very negative. I remember giving someone 100 of demerol when I should have given 75, for example. I wrote an incident report. So the next day the head nurse wrote on it, "How could this have happened?" I thought, quite easily. I picked up the wrong bottle. That's what happened. I didn't look close enough. That's how it happened! I felt that comment was really unnecessary. It just didn't seem like a big deal to me at the time. I wrote the report; I could have easily covered it; I could have but I didn't because it's just not right. I've made worse errors before and when I've reported them the charge nurse has said, "Yeah that was pretty bad, you know, you have to really be careful" but this was probably the smallest one I ever made and I felt it was like a death threat. I couldn't believe it. It was so stupid. Well, it didn't seem that important to me. That kind of feedback can be so negative, even when you don't* *do things perfect! I did some really good things that night! That's why I felt so sensitive about it because I thought I had really worked hard and had done some great things and I wasn't acknowledged for that. I was acknowledged for 25 milligrams of demerol!*

Ann: *Did you say anything to her?*

Sue: *Oh no, you didn't approach this woman. It just wouldn't have made any difference. She's not visible on the unit ever. She just shows up once in a while and tells us to work harder and leaves.*

Sue tries to improve her practice and those of her fellow nurses by getting better access to patients' charts and improving their understanding of care for suicidal patients. However she is 'made to feel like a little child' and nothing ever became of it. Her work experience has reinforced that nothing changes and 'why should she think it would be different'? It is difficult to dialogue with others when your ideas are ignored, when your errors are magnified and your accomplishments aren't acknowledged. It is not hard to see why many nurses choose just "not to pursue it any more," if one can't win. It may be a chicken way out but experience says it isn't worth it.

The consequences of meager sustenance

Janet: *I think one reason our head nurse has difficulty understanding the staff nurses ethical concerns is because she has very little contact with the patients. She doesn't know the heart rending, emotional 12 hour shifts that you spend with a patient who is going down the tubes. You are hanging blood just for the sake of hanging blood because it's going in one end and out the other. She doesn't understand that turmoil. Either that or she's blocked it out of her memory from her nursing career. I just find that there's no compassion for the nurse so that at the end of 12 hours she can go to someone and say, "My God, I'm an emotional wreck!"*

There's no one you can go to within our unit. Meanwhile you are going home in between those three 12's and thinking, "Oh my God, I have to go back and do it again." Or another example is that your patient has just expired and all of a sudden, you are the extra body. So ten minutes later you've got to take over another patient. No one senses that you need a time to just block everything out and be by yourself or to have someone listen to you. There's no spare moment in there.

Noella: *There's no hug there, that's for sure. I find that those feelings would come out at home or at night. You wake up at 2 in the morning, your heart is racing, you are sweating, you can't sleep, you are just panicky. Or else you phone somebody and you knock your husband or your friends. You develop this kind of black humour that you use and eventually you realize that it's inside you. There's something that's crying to get out and it's just the release of these pent up feelings that you couldn't express somewhere. I'm not saying that you should be able to just go and express everything at work but if there was just somebody you could talk to that would understand, because your husband doesn't understand. Mine doesn't.*

Maureen: *Sometimes though you need to talk. Our nurse manager is great; she senses that. If you are upset, she will come over to you in the middle of the day, no matter what you are doing, "Are you okay?" She will give you a pat on the back or whatever; she's really good. I find we are all very supportive of each other. When you work 12 hours with people, you get to know them. You know if they are upset about something. Sometimes we use our coffee breaks to "just spill our guts". Sometimes you need to go up to somebody and say, "That's really rough that you ..."*

Janet: *I think our talk at work is often very superficial because no one really wants to "know you" as a person. I mean it's nice to know you as a nurse but beyond that, unless you are friends with that person outside of the work situation. But people are so superficial that they don't really want to get in under that first layer to find out what kind of person you really are and find out your responses. We have a senior nurse that has very black humour because that's the way she copes with being in this type of situation. She's just very distant, and anything can happen in that unit and she will be stable as a rock. She won't show any emotion, so you have to wonder what her coping mechanisms are when the rest of us are on the verge of tears.*

It is difficult to maintain a personal safety in their professional life. When one feels alone, alienated and not understood there is a high cost to physical and psychological well being. Besides somatic illness, these nurses often report a free floating hostility, a distancing from others, and a very black humor. These experiences in nursing are very energy draining.

What would make that a different experience? It seems that a simple "Are you okay?" and pat on the back does wonders. Sometimes there is a need to "spill our guts" and have a colleague acknowledge "that's really rough". The feeling of belonging in a bigger human matrix makes this experience of nursing one which is energy giving, complete with the joy and the pain.

The final section of this area tells us how this transformation to a preferred reality might be experienced.

A preferred reality

Noella: *We'll present some kind of proposition to our head nurse in writing because that's the steps we are supposed to be taking. It gets lost in the office. Then a month later we are still waiting for an answer which could have been done* *within an hour and returned to us. It gets lost in the shuffle. It's just not important! There's a great starting but no continuation. We can't seem to emphasize to her how important it is to the people on the front line to either have a chronic care plan for the dying or to have ethics committees come in and just be able to speak about it. What can we do for ourselves? We say in the unit that it's easier to get forgiveness than permission so let's go and do what we can do. If we step out of line, we will be forgiven but to try and ask permission from her to do what we have to do is wasting our time. We found that by doing it the other way, we are getting so much cooperation from people outside the unit, like from the ethics committee and new information on pain control. We are just phoning other units and asking, "Have you got a care plan for the dying?" We are getting this all together and we are letting the other nurses in our unit know by offering them a rough draft of it. We say give us your constructive criticism. Don't tear it down. Then when we get their feedback we are going to try to implement it. It's kind of based on that nursing governance model. We are going to do our own thing. Then we are going to show you (the head nurse) what we've done and then it's up to you to okay it. If you don't okay it, we are still going to do it if we find that this is what is important to us who are doing the work. We seem to have support of people above you so it's not like we are stepping way out of line. We are just kind of stepping over it a little bit. It's just life. If you can't get it from one person, then you go one step higher. You just keep going higher until you get what you want. It has nothing to do with nursing. It just has to do with survival!*

Sue: *The bottom line is that nurses in a hospital will always be working shift work. It would be a real welcome change just* *to know that I have a little more control over my part. I think nurses have a lot of good ideas about how to make the system more effective. I've never seen any implementations of staff nurses ideas. The staff nurses are the ones who do the patient care. That's supposed to be the most important thing in a hospital but yet I don't feel that staff nurses are really valued. What I would try to do is give them some more decision making power and for them to have more input into realistic things. We are just the ones who do the work. If you want really bright women to go into nursing, it cannot be that way. It's a world where everyone wants what they say to be important and to have some input into things that involve them directly. Well, it's starting but it has to come from us. I mean nobody's going to come and give this to us. We have to say, "We want it and we are capable of doing it!"*

Maureen: *Our unit manager is pretty good. I don't know if you've ever been up to our unit, we have the most archaic equipment and it's very frustrating. We have unconscious patients and we get them up in a chair twice a day. We came to her with our ideas on how to get money because we were turned down for any new equipment in the last budget. One of the girls said, well, why don't we hold a dance, we'll sell tickets. Then she knows, hey, these girls are serious about getting some money for equipment. Another of our nurses has gone to the city Police and asked them if they would consider sponsoring us for reclining chairs and stuff. So we've shown her that we are interested in getting this stuff and considering she has no funds for it, we've gone on our own. I don't know how far it will get but that's what we are going to do.*

Noella says sometime it is necessary to "step out of line, a little bit" as a matter of survival. The actions are not careless but politically astute and determined. The revolutionary cause - ethical concerns for dying patients. They will do it because it's important to people on the front lines but they hope to be forgiven anyway.

Sue, who in previous pages told about her frustration with her sense of powerlessness has a vision of how things might be otherwise. It's starting, but it has to come from us ... we have to say we want it and we are capable!

Maureen tells what staff nurses who were interested and serious are going to do to get what they need. We hear that this nursing community is "in it together" to deal with their frustrations.

> Only a shared understanding will encourage the individual to endure ... the reward of patience is vigor. Vigorous people reflect the firmness of reality, the resistance and dignity of things that challenge us in a clear and present way. We must acquire the patience to locate and nurture focal things.
>
> (Borgmann, 1992, pp. 125-126)

Borgmann goes on to encourage us to give up the restless activity grounded in the hyperreal, to come to terms with nature and tradition in a patient, vigorous way and to forge an inclusive sense of community.

The nurses in this study explored their position in the midst of longing for the hyperreality of the mother heroine to protect, support and nurture them and at the same time have an image of an organic community in which they can be responsive to the needs and dreams of themselves and others.

Relationships with Physicians

We have come to wonder

> From the late 1800s until just recently, female nurses were *twice* socialized into the feminine role of submissiveness, dependency, and subservience, first as women in our culture, second as nurses in hospital-based schools of nursing and hospital work environments. Both the schools of nursing and the work environments mimic the dominant male/submissive female role.... Nursing students, and for that matter nurses were taught and expected to "know their place," to be an example of culturally prescribed feminine qualities, and to serve obediently and silently. This double socialization of nurses is epitomized in the motto chosen for the first school of nursing in Canada: "I see and am silent" (Cockburn, 1981, p. 186).
>
> (George & Larsen, 1988, p. 68)

What legacy do we inherit from the handmaiden image? What is the ground underlying the difficulties often experienced in Doctor-Nurse communications? What responses are possible in the everyday encounters? What have we experienced that engenders hope in more respectful, understanding, human relationships?

The following narratives tell how the critical care nurse makes sense of her relationships with the physician as "the significant other" health care professional with whom she has the most intense interactions on a daily basis. It is striking that stories of problematic encounters outnumber stories of compatibility almost six to one. This is an area which many nurses find difficult; the following pages help us to understand why.

The first three sections tell how the old handmaiden stereotypical expectations are still present in nurses' lives. The next three sections describe situations of hegemony and conflict. The last section provides several examples of the type of desired responses that nurses wish would form the basis of their inactions with physicians.

Instrumental relationships

Sue: *There was one doctor that when he did rounds, the unit had to be quiet. That used to just peeve me because we all had work to do; but when he was there we all had to speak in hushes and if we didn't, we were reprimanded. It was like, "Sue, be quiet!" It really bothered me tremendously. I thought that was so disrespectful to the rest of us. We had work to do. His job wasn't the most important job on the unit. It was one of those things that made me feel like because I'm a nurse, I have to abide by this silly rule. I felt like I couldn't even challenge it - there was no where to go with it because it was just there and we had to live with it. I hate stupid rules if there's no reason!*

Another thing he wanted, was all the babies had to be lying on their back, so he could assess them. He wouldn't *move them. He'd be mad if he had to move the baby. So of course everyone had their little babies flipped over for him so he could examine them. It didn't matter if it was not good for the babies to be on their backs. It reminds me kind of the military and "stand for inspection".*

Heather: *Their heads have to be lined up here and their little feet have to be there!*

****

Nancy: *When I worked in the States, because it was a non-teaching hospital, the doctors treated us more as a team because, when they went home at 5:00, they didn't have a resident to leave behind. They had to depend on us. I learned an awful lot. When I came back to Canada I found it interesting because the unit I worked in here had different expectations. I had a post open heart patient who started to throw PVCs (heart rhythm irregularity) and was on Digoxin. The first thing that I thought of is that he's dig-toxic and we should do a dig level. When the residents and the doctor came around in the morning they were talking about these PVCs. I said, "Think it could be dig?" And he ordered a digoxin level but he did it in such a way - we'll humour the nurse! Well, we'll get a digoxin level because that nurse thinks we should get one. And the patient was dig-toxic. Now, to his credit, he did apologize the next day in front of the residents. He said to them, "See, you should listen to the nurse." But it wasn't with the strong feeling that the day before he said, "We'll humour the nurse."*

It's no wonder Sue is reminded of the military; command, reprimand, uniformity, and unquestionable authority were the "order of the day." Nancy's story is a bit more subtle. When the doctors needed the services, they delegated responsibility (to stand in for absent doctors-in-training) and depended on the nurses to take care of things when they were off-duty.

Nurses have wryly called this the 'Law of the Sun': when the sun goes down the nurses authority goes up!

However, later it was inappropriate for the nurse to suggest (even to know) what the patient needed when there were sufficient real doctors present. "To his credit" (in the 1990s) his patronizing attitude was mollified the next day by a feeble apology in the face of scientific evidence.

These narratives clearly speak of the nurse's role of service and obedience as being firmly entrenched in these physician's attitudes.

Climate of blame

Nancy: *I remember this one specialist and his residents - they became monsters once they got to our unit. And there wasn't a lot you could do about it. One way of dealing with it was that we gave them nicknames. Well, Tricky Dick is probably the most meaningful example because if you were on nights and you phoned him, he would answer the phone and make orders in his sleep. They would be very appropriate orders, but then the next day he'd deny that you ever called him. So when you called him at night, you had another nurse on the other phone and you both signed the orders.*

There was one case where he had basically screwed up and he tried to blame the nurse. A patient who had come in for a coly (gallbladder surgery) had coded in the recovery room. She was about 75 years of age. When she came to us, her vital signs were not stable and we were phoning him all the time and he was putting it off, putting it off! It was one of these cases that everything goes wrong. Eventually he came down, lost an IV site, had somebody come down to do a cutdown. It went into the artery instead of the vein so that she ended up losing her arm as a result. But from the moment when things started going bad and the family started asking questions, he was trying to put blame on the nurses. Unfortunately for him, *we'd been through this enough times with him that the nurse had very carefully documented every time she called him and he wasn't able to do that. He was not somebody that you could trust farther than you could throw him. So we had the nicknames for them. We could talk about them and nobody would know what was going on.*

Noella: *One of the residents was upset with us because we wouldn't call him doctor - we call all the guys by their first names. One of his comments was that there was no respect because we called him "Tom" instead of "Doctor". So that started a little something; we called him Tommy after that! (Laughter)*

Nancy: *Our residents did thoracic surgery, and one of their "favourite responses" concerned patients whose urinary output was not adequate. When you called them to tell them they'd say "It was perfectly adequate output". They would make light of things that were significant. If a person has a urinary output of 5 c.c. for 4 hours, there's a problem and they would say, "There's no problem".*

We never did this but talking about it was a way of breaking the tension. We used to say, one of these mornings when they make rounds we're going to put just a tablet of lasix (a diuretic) in their coffee. It will hit them about the time they go to the OR. They will learn what a good urinary output is! So, we would think about how can we get back at these guys. We'd talk about it and never do it. But we were at least able to get rid of some of our anger by doing those things.

I had a patient of their's once who had had a femoral aneurism repair. And, through the night, we couldn't get a pulse in that leg. By morning she had a fever. Now, their last order before they went was that they wanted her to get up *in a chair that night. We admitted a couple of overdoses and a bleed and getting this person up in the chair was the last priority. The person did get chest physio every hour.*

Well, they said the fever was our fault for not getting her up in the chair. They said, "She probably had pneumonia because we didn't get her up in the chair!" The woman had to go back to the OR later that day because of the graft not working and the fever was from ischemia. During the night they would not listen to us when we said, "Look I'm not getting a pulse, she's got a fever, the skin's going motley." They said, "Well, no, it would be okay." They just had total disregard for us and then when things would go horrendous, they still wouldn't listen. It had to have been something else we had done. We hadn't got her up in the chair. Now, people don't usually have grafts go bad because you don't get them up in a chair. They always had to be blaming us. So we didn't have any respect for them. They probably were okay in the OR, they just thought they were the only people who had any knowledge, any expertise at all.

Noella: *I found that happened in our unit too. One of my first patients to arrest had just come back from the OR. He was fine, stable as a rock - his wife was actually in visiting. He was on just a little bit of nipride, a little bit of Dopamine. She was standing there talking and I noticed the blood pressure going down, so I just sat and I turned the nipride off, I sat back and looked at it and it kept going down a little bit further. I thought it's going to go back up as soon as the nipride stops taking effect, but it didn't! So I can remember going around the foot of the bed and holding his legs up and saying to the wife, "Maybe you should step out for a minute." She just got out the door and he arrested.*

> *It wasn't five minutes before this episode that I had taken all the blood work, ABGs and everything and sent it off. And there were no other symptoms leading up to this. There were no arrhythmias. There was nothing, I had no idea what had happened. And of course the Code was called. They opened him up and took him back to the OR. And when I asked what caused the problem, I was told it was a raging acidosis and his base excess was minus 2. And I thought, "That's not a raging acidosis! Come on!" But there had to be blame put somewhere, so it was that we hadn't treated the base excess of minus 2. Well, I hadn't even got the lab results back yet! I just thought, "No way!" It's just that there had to be blame laid somewhere and it was being laid on me. How was I going to shake it off? I wouldn't be able to just say, "Well, everybody knew that it wasn't a raging acidosis that caused this!" So what I started doing, if anything happened to my patient and they passed away, I wanted to see the autopsy. I wanted to know what was on the autopsy so that they couldn't say to me, "Oh, it's your fault because it was a raging acidosis" when it could have been, you know, a clip blew or something - or some other reason. It was funny how, when I started asking for autopsies that other things were coming up that caused the death or else they had no idea what happened. It wasn't blamed on me.*

Nancy and Noella speak of an aspect of their work lives that make them feel very guarded, very unsafe. They feel positioned on the pecking order far enough down to be seen as powerless to defend themselves and high enough to be held responsible for problems. They feel targeted not only because of their vulnerability but because they are expendable, totally disregarded. They respond to this blaming by carefully documenting their own and each others actions and calling on the 'unbiased science' of the autopsy for protection. They respond to these attacks on their competence with covert anger couched in coded nicknames and daydreamed revenge. How many options does a potential scapegoat have to keep the danger at bay?

The deference game

Heather: *It depends on the doctors but a lot of times, you have to play little games. If you want something ordered for your patient, and if you just ask him to order it, he's not going to do it because the nurses shouldn't tell doctors what to do. You have to make little games where you phrase it in such a way that they think it's their idea. You really want to say, "Look, this guy needs such and such" but you have to play these little games to get them to order it.*

I feel really annoyed. I feel I am manipulating them in a way. It's a ridiculous relationship because I am treating them like children in that I am manipulating them to do something that I want them to do. It would be much more satisfying to have a direct adult relationship where I can say, "I think the patient needs this."

Sue: *It's not the kind of relationship I engage in in my private life. I like having the same relationships in all aspects of my life. I hate to manipulate to get my own way. I just like to come out and say, "This is what I need or I want." So I know what you are saying.*

Heather: *And it depends where you work too. I've worked in intensive care where it's not like that at all. It was a wonderful place to work because the nurses were given credit for some intelligence and some experience. Growth was encouraged and learning was encouraged. There was a lot of opportunities to go to inservices or grand rounds. You were encouraged to take part in teaching sessions. Nurses presented different topics for inservice and the doctors were willing to teach you, even spontaneously. If something came*

> *up and you asked them a question, they didn't act as if you were an idiot, that you didn't know a thing. They would explain it to you. Yeah, whereas the other place I worked in, I found this particular hospital, the doctors were very paternalistic - not giving nurses much credit. I really think they saw nurses as their handmaidens, so it was a less pleasant place to work. Nursing administration wasn't particularly supportive of the nurses. There seemed to be a more "us against them" type feeling which was probably a lot on the nurses' fault but it was the medical staff's fault as well. But you didn't feel supported if you took a stand against a doctor. You didn't particularly feel that your head nurse or your supervisor would stand behind you.*

Heather describes what nurses often refer to as the Doctor-Nurse Game in which there is a strong pressure for the nurse to carefully orchestrate an harmonious interaction designed to comply with perceived need to bolster the physician's fragile ego. This game assumes that the doctor needs to always take the initiative, to be in charge, to be all knowing.

Sue echoes the sentiments of most of her colleagues in that this is the kind of interaction they try to avoid in their private lives. It puts them back into the ridiculous role of childish manipulation instead of a "more satisfying direct adult relationship."

Heather reminds us that all settings are not so paternalistic. Growth is possible if we can leave behind the hierarchical structure of the nuclear family and relate as adults in a more egalitarian respectful manner.

He won't listen

Nancy: *We had a patient who had gone to surgery for cancer and they had never been able to get him off the ventilator. You had to be in the ICU in this hospital if you were to be on a ventilator and he was there a long time. His cancer had been* *inoperable and he used to write saying, "I'm going to die anyway, why don't you get me out of here? Why are you keeping me alive with the machine?" He developed a urinary tract infection and the first symptom was that he indicated he was having bladder pain. I remember - it was on night shift and I took a urine sample and the resident was passing through for something else and I said, "Can I have an order for Pryderium to put down his gastric tube because he was having this pain?" The resident didn't really feel it was needed but he ordered it, again to pacify me. As he was leaving the unit, this guy was awake and called him over and indicated he was having pain and then it was, "Gee, you are right!" I thought, "Well, surprise, surprise." Why did he need to have that validation? The patient had been telling me all evening!*

Janet: *Nancy had made a point about people who don't listen. That occurs on our morning rounds time and time again. The residents are supposedly there to hear your report, but they're chatting to each other as you're giving the report. They're saying, "Oh, yeah, we have one ear to you and we can carry on a conversation at the same time." When you're done, they ask you the same question that you just told them. You think, "Why am I here?" Well, occasionally I've stopped and just waited and then I've been told, "Go ahead," and then they start up and I stop again. You know, why bother? One of these days I'm just going to take the sheet and say, "Here, you read it. Do the best you can." They don't know where to find stuff. That's why they stand there and they want a verbal report on everything, because they wouldn't know where to look for it on that sheet.*

Noella: *Their residency is three years and they still can't read it!*

Ann: *Does that strike you as being strange, that maybe* *something else is going on here? Could you imagine being in a workplace where you can't read the main document for three years?*

Janet: *It amazes me that they get away with it. And nothing is done to reprimand them and that's what really kills me. And yet if we were to hand them our flow sheet, your rapport with them is further cut because they don't have much respect for us or for our opinion anyway. It seems a lot of our verbal report is like to a deaf ear.*

"He wouldn't listen" is probably one of the most common recurring phases in the stories of interactions with physicians. One might well ask, "What's going on here?" Verbal and written communication from the nurses seems to be discounted, invalidated. How is it that this "vital" information about patients is made invisible to the eye and inaudible to deaf ears. What amazes the nurses is that they get away with it. But the nurses are hesitant to shout into their 'deaf ears' lest the tenuous rapport is cut farther. It isn't clear if the physician's lack of attention is because he does not know better or does not care. Possibly they are the same, in this situation.

A struggle in language

Marie: *I remember one nurse having difficulty with a patient and the doctor she was calling that night wouldn't do anything - wouldn't come in. The patient died by morning. There was a power struggle in there to a certain extent and a lot of it has to do with personalities. Basic personalities of the person that they bring into the work and you have to deal with them in that setting.*

Ann: *Which power struggle are you talking about here? We've used that term in a couple of ways. Who is struggling?*

Marie: *The nurse who has to deal with the problem and can't get anybody higher than her or with more knowledge, to do something for the patient. She's the advocate for that patient.*

Sue: *When you think about it, why wouldn't he have come in? I've never understood why they've said, "Don't worry about it or I'll be in at 8:00 a.m.! You know, somebody is phoning and saying there's a real concern here! I've never understood that because it does go on and it happens more than it should. So I wonder if there is a power struggle! I wonder if the physician knows who he's talking to on the other end of the line!*

Marie: *Maybe it's just comfort, he'd prefer to be home in bed. "They don't want to go out in the cold, or some lack of trust in the nurse on the other end who's talking to him and lack of trust maybe due to their age. Maybe they've been in the business for a long time and they thought the nurses were much below them.*

Heather: *Maybe it's not giving people credit!*

Sue: *But to me, anytime someone would have a serious concern, I would look into it. I would personally want to see what's going on as opposed to getting the information over the telephone.*

Heather: *But what if you thought that you knew more than the person who is calling you? That maybe the person who is calling is just panicking and that you've seen this patient before and they were fine. I think it's a lack of respect for the person who's calling you. I always felt that maybe I didn't say it correctly. I get off the phone and I think maybe it's my fault; I didn't give it enough sense of urgency.*

Marie: *Or maybe I didn't have the "stats" (quantified physiological parameters). I didn't have enough stats to prove my point.*

Sue: *Maybe I didn't make it sound as important as it is!*

Marie: *And some of it may be intuition with this patient. You just know something is going to turn really sour here. You* *don't have the numbers to prove it, they are not bad now but the patient is not looking right.*

Sue: *But the bottom line is the patient. The bottom line is that if somebody phoned me and said there's a problem here I would come in, for no other reason, than just to make sure the patient is okay.*

Heather: *But maybe the bottom line for them isn't the patient.*

Marie: *The number of calls that they do get to come in is really minimum for the most part. The nurses do a very good job of getting orders over the phone.*

Sue: *Even more reason to come in then if somebody phones and says 'I need you here'. Even more reason to show up - "Get in your car and show up quickly!"*

Heather: *But I think it comes back to how much respect the doctor has for the nurse who is calling. In general, a lot of doctors don't have that respect. They really don't think that the nurses can look at a situation and accurately analyze what's going on. And I really do think that is the problem. I think that one difference between you and the doctor is that you would rather be inconvenienced unnecessarily because the patient is the most important thing and I honestly don't think that the doctors in the long run think that the patient is the most important thing.*

Sue: *That's something I'll never understand and I don't want to believe that that's the reason.*

Heather: *Maybe I'm wrong but that's what I feel the reason is.*

Sue: *Yeah, could be. I think it depends on who calls and everything else.*

Heather: *Yes, the relationship you have with the doctor is important. And the doctor who is on, too - definitely the doctor who is on makes a difference.*

Sue: *And then I guess there's always that question, like it's three in the morning, am I over-reacting? Like really is it that important?*

Heather: *I think that we accurately estimate and I really think that most nurses do not call the doctor in the middle of the night unless they are really concerned. I think that nurses on the whole don't call the doctor at three in the morning frivolously. You do whatever you can and use whatever resources are available in a hospital first before you'll disturb a doctor. I feel that if I do call a doctor, that he'd better damn well come because I don't call unless I'm really concerned. And I guess it depends on how you express yourself and if you act as if you don't sort of ask them if they are coming in, but you act as if your assuming they are coming in.*

Sue: *Sometimes I say "What should I do before you come in?" I just remember sometimes having real problems when I would call the physician, he'd say, "I've been on call all weekend, I'm really tired." I feel for you and I understand it but too bad! I don't know what to do here. I'm in a real problem, this kid could die! I don't have the authority or the knowledge to do anything beyond this. I can't put in chest tubes, I can't intubate. I don't do those things. It's a terrible feeling, it really is!*

This conversation gives us some idea of how complex the communication difficulties between many doctors and nurses really are. They suggest that it seems the physician often doesn't really "know who he's talking to on the other end of the line". Some possible explanations are explored. Maybe there is a language barrier between speaking of intuitive hunches and the proof of "numbers". Is there a power struggle going on? Does it have to do with authority?, with knowledge?, with advocacy? They say it depends on who the nurse is that calls for help, who the doctor is, and the relationship they have with each other. It revolves around value systems and respect for others. Whatever the components of a given situation, it's clear that the bottom line is that "It's a terrible feeling, it really is!"

Confrontations: Alien worlds

Sue: *I don't think confrontation is all bad. I'm willing to engage in it. I don't like to exchange blasts but I'm willing to engage if I have something that I think is important to be said. I'm willing for someone to say, "She's a pain in the butt."*

Heather: *I think you have to get to a point where you're confident with your knowledge and your skills and yourself. I can remember one time when I had first become a permanent team leader in this one intensive care and there was a new resident in the unit that I didn't know very well. There was a patient who was a post open heart patient and he was bleeding a lot. I called the resident and he came and gave the patient blood. I kept saying, "You should call the surgeon" and he didn't. He kept doing more and the patient kept becoming more and more unstable and I kept saying I think you should call the surgeon and he didn't. Finally, he did call the surgeon and they shipped him into the OR and there was a big panic and actually this guy did not do very well. He was quite a young guy but his blood pressure had been too low for too long and he suffered some brain damage and I always felt guilty about that; I felt that I hadn't pushed enough. It was mainly because I wasn't really confident in myself. I think that if that happened now, I would have had no hesitation of saying "Well, boozo, call the surgeon or I will."*

****

Janet: *Recently a young fellow in his mid-sixties had by-pass* *surgery, but he came out of the OR with a V.A.D. (a ventricular assist device) and an intraaortic balloon pump and mega inotropes on mega drips and lots of ectopy. You know, just very unstable! Within 36 hours, he went back to the OR three times. Everything was just diminishing, all his vital signs were not good. The family was told by the physician that he had a 50% chance and after each OR even though the percentage diminished slightly, the physician still gave that hope. So the family was under the impression that, regardless of how low that percentage went, that this patient will survive. But the doctor wasn't honest in saying "survive" to what extent? To get out of the unit and die on the floor or to survive maybe six more hours in our unit?*

Nancy: *Medicine judges survival in strange ways. It's that whole thing - you know, the operation was a success but the patient died, and that's the mentality. When I was in a place where they were first starting to do the heart/lung transplants, the "success" was that the patient lived six hours. Well, that's not success to the family or to the patient! And so I think their definition of success is really bizarre.*

Janet: *And I'm thinking, "Where is this doctor coming from and what has he told the family and how does he expect us to go on and keep on just doing!" And I was just beside myself.*

Nancy: *Do you think part of that is, for some physicians an inability to accept the fact they can't do anything? I say that because my mom had terminal CA and she died at home. She died at home because there was a family practice that had four doctors and each doctor had interns and residents. They visited twice a day the way they would have in a hospital, and I was able to be home so I could take care of her. Most of the residents who came were very supportive because they* *thought we were doing the right thing. But the day before she died, a resident came along who was so uncomfortable with a person being that sick and not in the hospital that it was transparent. She had lost her IV line at that point. He phoned his chief because he couldn't get an IV site and his chief said, "Well, you give the family two options. They can either keep her at home with no IV or she can go to the hospital and have a cutdown, but it's up to them." We said "Well fine, we'll keep her at home." And the look on his face, that somehow we had grown horns and turned green because we hadn't opted out for the hospital. He was totally appalled. And I said to him, that she hadn't been putting out urine, and I wasn't sure whether she was retaining urine. I said, "What do you think about putting a catheter in?" He says, "No, you can't do that because there's the risk of infection!" And I thought this guy is definitely on a different planet. They were saying it's a matter of days, but he was so caught up on this infection/medical model. He needed to cure, to feel he was aggressively doing something. He just could not deal with the fact that we had said, "Well, this is the end and we want her to die peacefully at home." And I wonder if that isn't part of it too in situations like that, where this person's not come to the point where they realize that they can't win. You have to just accept that you work towards doing the best you can but also knowing when to stop.*

Janet: *But this surgeon, this particular surgeon won't take on the responsibility of saying that's enough.*

Nancy: *I think it's almost like he's never gone beyond a certain point of maturity.*

Janet: *Well, I don't think he knows how to accept death. Maybe it's the kind of bond that the surgeon and patient have: the* *surgeon has done all this work on this particular patient in the OR and they feel a closeness by doing constantly and now that he's realized he can't do any more, it's very hard for him to let go.*

Nancy: *The last unit I worked in, we used to get the neurological patients who didn't do well in the operating room. They were usually on ventilators and we were the only unit that was allowed to have ventilators in the hospital. Because we had a neurological ICU the only time we got a neuro patient was if they'd gone bad. We very seldom got to see anyone who was going to make it out of the unit. And the neuro residents were S.O.B.s in our unit. The neuro nurses would come down and say these guys are sweethearts! We're sitting there asking "What happens between 3rd Floor and 4th Floor because with us they're horrible!" Finally, what we understood is that it's because we have their failures.*

Maureen: *Yes, you're seeing their failures and that's all you saw.*

Nancy: *And that they were okay in the other unit because they were succeeding up there but because we had their failures, it was their way of dealing with their frustrations. It wasn't that they were abusive to us but they were just really difficult. You'd call them and they wouldn't call back. They weren't attentive to us. But, until we realized that's what was going on, we were ready to strangle the whole lot of them. Then it was better, we still thought that it wasn't appropriate for them to act like that but at least we could live with it a little bit better. These guys aren't exactly the assholes we thought they were. They were just dealing with something they didn't want to deal with.*

Noella: *I also don't think that these particular physicians see the patients as nurses see them. They don't see that there's a person behind all those organs.*

Maureen: *Yah, it's not just a "heart".*

What are possible responses to the communication difficulties we explored in the last section? In this conversation the nurses discuss their experiences in confronting, negotiating and trying to understand across these barriers. We are told to take action in these situations takes a confidence in your "knowledge *and* skills *and* yourself." The nurses sense a need to protect the patient from "inappropriate" medical treatment and patients' families from the pain of false hope. Often the experience of trying to communicate across these gulfs takes on the qualities of encountering aliens from space. At times however it is the nurse who is perceived to have turned green and sprouted horns. The conversation ends in wondering if possibly the root of this difficulty may lie in the physicians commitment to a "constant doing". When that "bond" is broken because the doing has failed, it is really frustrating for the doctors to deal with patients as persons not just "as a heart".

The desired difference

Heather: *I worked in one intensive care where we had a young man who was only about 34, 35 and he had surgery in a small town on the prairies. It was abdominal surgery and it ended up that he had developed DIC (severe bleeding complications). He was rushed to our hospital which was one of the major centres for Saskatchewan. He was conscious when he came but he was bleeding a lot and it was a real crisis situation. They were pouring blood in him and trying all these things to stop his DIC. We got very attached to his wife. Everybody there liked them both very much and everybody was really trying hard. It ended up that the cardiovascular surgeon came in to put an intraaortic balloon pump because he was going into heart failure. They were just trying to do anything that they could but he did die. There was just such sadness and everybody just felt drained and hadn't had any breaks or anything. The surgeon wasn't a particularly friendly man; he usually was* *sort of distant and polite. He came around and thanked everybody personally. He put his hand on my shoulder, "Thank you very much," and I really felt that I was part of a team. We all were a help and he appreciated our efforts. The other doctors always thanked us but because it was a very sad occasion, it just made you feel appreciated.*

I've worked in another intensive care where we had a gentleman who had bowel surgery and he ended up going sour. We were doing CPR on him and a surgeon come down and opened up his stomach right there and in intensive care sucking all this blood out. We were doing CPR for an hour and while we were taking him up into the OR, you know, the blood was coming from his stomach and my hands were slipping all over and I was tired. I was doing CPR in the OR until they got him anaesthetized and nobody said, "Thank you" or "We appreciate it" - it was just - "Okay, you can go now." And it was just such a different experience.

****

Nancy: *I was looking after my first open heart patient on my own at night and I didn't call the patient's doctor when I should have called him. He came and made rounds and he came up to me afterwards and he said, "I realize that she is your first open heart and I just want to tell you that this and this happened and you should have called me, but I'm not blaming you because you're new. I was petrified. I thought, "Oh God, I'm never going to make it here." The next night, I had another one of his patients and nothing went wrong. The next morning he said to me, "They're kind of boring when they're stable, aren't they?" He knew he had to say something to me that morning because he knew that I'd been upset.*

Noella: *That reminds me of the doctor who has recently came to be the director of our unit. He saw right away that there was* *very poor communication between the nursing staff and the residents and the physician's assistants. He kind of took all the residents and guys under his wing. They had to go to have breakfast together. If the nurses were down in the cafeteria, they had to sit with the nurses and talk with the nurses. When he comes down, he sat and talked with us and he made me feel more as part of a team. I wasn't just there to do their work or what they considered my job. I would do my job but I was a part of the team. I've found that since he's come, the whole attitude of the unit has changed considerably. He has so much respect for the nurses. What surprised me is that, the first day I met him, I told him my name and my name's not an easy one to remember, and he always knew it after that. In his first few days he commented that that's one thing that he wanted to know - everybody's name. But he is consistent in showing concern and caring. I thought he must really care about us if he's going to come and sit at our table and share with us and it wasn't just like he sat there like a lump - he was laughing with us. Like you're a person to him!*

Nancy: *Yes, one specialist I worked with did the surgery for basilar aneurysms and some of the patients didn't do well. He was very realistic. I can remember him coming up to me one time very quietly while I was doing a range of motion on the patients. He said, "You know, it's really sad when they're like this and you know they're not going to make it!" He still had his humanity. He could still accept when his patient didn't make it. He could be human about that, and was not going to flog a dead horse. He had come in that time to order another ECG to see whether they could say brain death had occurred, but he was so accepting of it. Maybe because he'd done so much and there was so many people he'd saved that wouldn't have been saved before he developed his technique -*

> *that may have been part of it - but he could accept both sides of it. And it was interesting because we used to get people from all over the world that came for him to do surgery. He'd give his home phone number to the people from other countries and say, "You can call me anytime day or night if you need to talk". His residents dealt with them usually, but he always left that channel open that if they just needed to talk to him, he was there.*

It is no coincidence that the last three accounts celebrate the individual "person". These heros know and care about patients, families, nurses, residents - about fellow human beings. They talk with others by name, they laugh, are sad, are accepting and leave channels open. It makes such a difference when colleagues are respectful, responsive and humane. This desired relationship seems so simple yet so elusive to bring into everyday images.

CHAPTER V

HEARKENING TO THE VOICES

Recalling the Themes

What messages can we hear in the narratives of these nurses? How do their interpretations of their experiences of relationships in their professional lives speak to us? This chapter will first recall the general themes and then draw those conversations into a present first person singular response. I will respond to their voices in exploring the implication of these themes for me as a nurse educator.

I shall begin by recalling the themes from page 84. In the intervening pages nurses have described different kinds of web-work in their relationships with others. Nurses tell the stories of their professional lives; we listen and try to understand. Both the speakers and listeners interpret and try to make meaning in these dialogues. We each imagine possibilities, infer positions and translate responses. In their conversations they have related how they are continually making choices and constructing their professional lives in the midst of a multitude of influences. But they often tell of existential moments in which they experience living more in one sphere of influence than in others.

For the sake of demonstration I will describe two polar scenarios; like most binaries they are an illusion. However, an image is often a representation that epitomizes a dramatic example within a range of experiences. In this case I believe it has a heuristic value in understanding the subject positions of these nurses. Their conversations have made it clear that their lives are complex, ambiguous and often paradoxical. Together in our dialogues we have explored the tension of living in the spaces between the poles.

Image of self as caretaker

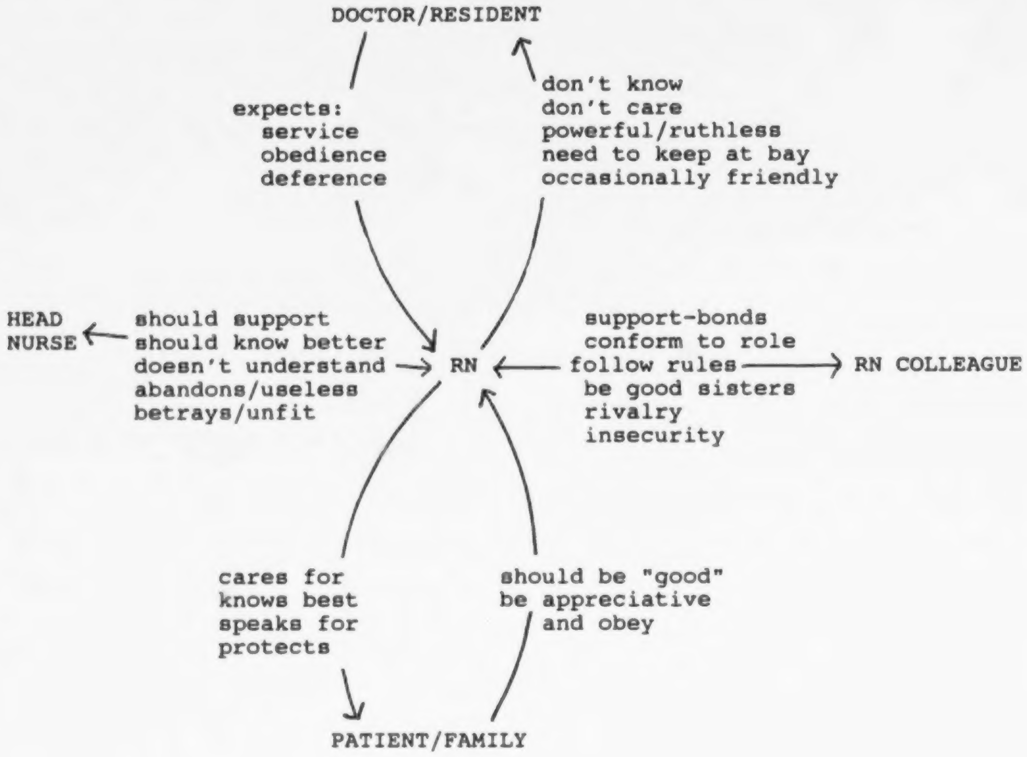
Often these nurses speak of being enmeshed in a system of interactions in which they imagine themselves in the position of caretaker. They are in the center of many conflicting expectations. Even though it is often extremely problematic to meet the needs of all the stakeholders, they take on the task of trying to do so. This often leaves them feeling ethically torn, emotional drained and physically "burnt out". Figure 2 diagrams this pattern.

The bottom of the figure repeats the constellation of themes associated with the image of self as caretaker. The diagram at the top is more explicit in how these qualities are lived out in specific role relationships. The nurse imagines herself to be in an hierarchical position to both physicians and to patients/families; there are separate arrows of relational qualities going toward and from each of these groups. However nurses see themselves on a more horizontal basis with head nurses and with work colleagues. A double headed arrow signifies the same set of descriptors which speak of the qualities expected from and given to each of these groups. These horizontal roles also prescribe very strict duties, obligations and expectations.

One of the central themes reported by the nurses is a sense of advocacy toward their patients/patients family. The nurse has the sense that she needs to care for, speak for and to protect them. However this "mother knows best" stance brings with it the expectation that the patient will be "good", obey and be appreciative.

The nurses seek the support/bonds of their sisters-in-nursing, but often encounter sibling rivalry, insecurity and a strong pressure to follow the family rules and conform to a prespecified role. When it works out well, these relationships provide a great deal of nurturance; when it doesn't it can lead to horizontal (nurse to nurse) violence.

Staff nurses desire and perceive that they need head nurses/nurse managers to be surrogate mothers in that they should understand the nurses needs and support them personally. This longing is often frustrated in that many head nurses are seen as useless and unfit when they abandon the nurses on the front lines and betray the nurses' best interests in order to appease physicians wishes or the budgetary prescriptions of the hospital hierarchy. This is all the more painful for the nurses because they have a sense that the head nurses should know better and should care.


DOCTOR/RESIDENT
expects:
service
obedience
deference
don't know
don't care
powerful/ruthless
need to keep at bay
occasionally friendly
HEAD NURSE
should support
should know better
doesn't understand
abandons/useless
betrays/unfit
RN
support-bonds
conform to role
follow rules
be good sisters
rivalry
insecurity
RN COLLEAGUE
cares for
knows best
speaks for
protects
should be "good"
be appreciative
and obey
PATIENT/FAMILY

Main focus:	task/role
Interactions:	hierarchical
Structure metaphor:	nuclear family
Patient metaphor:	as child
Nature of world:	secular, technological, material
Learning:	knows from experts
Guided by:	conforming to rules
Goal:	perfection in doing
Reward:	appreciation for doing
Self is:	instrumental
Self is:	less important than actions
Ethics:	prescribed by rules, right/wrong
Expectations:	to care for everyone
Responsibility:	duty/blame
Taking care:	control/support
Personal safety:	keeping proper place, distance, role
Nursing:	takes energy - work

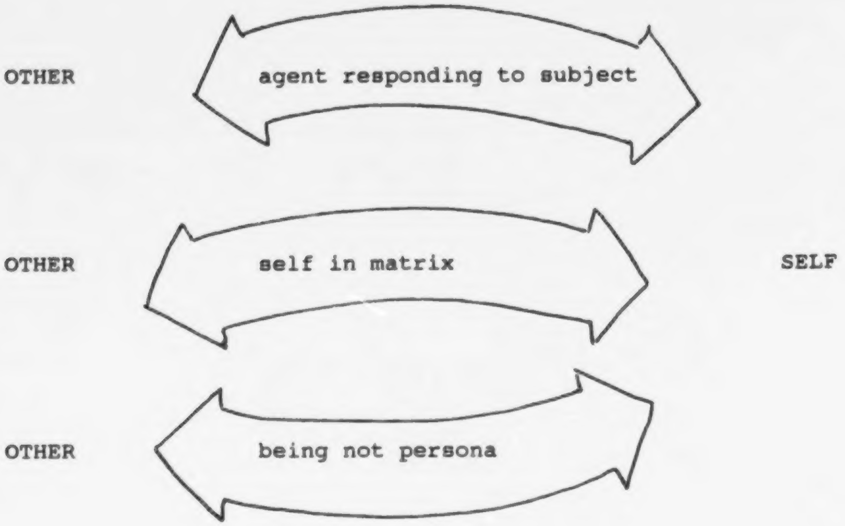
Figure 2. Image of Self as Caretaker

Most interactions with physicians are fraught with patriarchal/ paternal overtones. Some may think it an anachronism in the 1990s but the experience of these nurses indicate that many doctors still expect service, obedience and deference. The nurses describe interactions that are characterized by the approach/avoidance behavior of an oppressed group. The doctors are viewed as powerful. They are sometimes beneficent but often seen as dangerous in that they do not understand, do not care and, more personally, do not listen.

I suggest that two of the significant influences in the construction of this scenario are 1) the nature of the world in the dominant health care culture and 2) the gendered position of the nurse in that culture. The bottom of Figure 2 reminds us of some of the underlying values of this particular image of the nurse. These are the qualities that for the most part permeate the hegemonic structure of modern western health care. When we superimpose the gendered feminine role expectations, I believe the resulting image is not dissimilar to the diagram above those characteristics.

Image of self as a Being in relationship

There is another image of self that is distinctly articulated in the nurses stories, that of being in relationship in an alternative way to the one described above. This position has very different views of the nature of the world, our way of being human, and the influence of gender. Figure 3 indicates that the self in this matrix is more in the image of the dynamic autonomy that Fox-Keller (1985) describes. This self is a person/agent responding to other as person/subject. The focus is not on a persona of roles but the interpersonal relationship of beings. This diagram does not label the other as 'patient', 'doctor' or 'head nurse'; these roles are much less significant than the person who happens to be the doctor or the patient. The nurses would not deny the reality of the 'fact' for example, that a particular person is a physician and that this will have consequences in the health care situation. What is important here is that the role does not dictate the quality or description of the relationship. It may however influence the examples of how contextual aspects are lived out.


OTHER
agent responding to subject
OTHER
self in matrix
SELF
OTHER
being not persona

Qualities in relationships
of dynamic autonomy

Main focus: person/relational
Interactions: egalitarian
Structure metaphor: organic community
Patient metaphor: as friend
Nature of world: sacred, humane, ineffable
Learning: values knowing from experience
Guided by: personal reflection
Goal: to be in touch, in tune
Reward: just being there
Self is: ontological, epistemological
Self is: important as embedded in life
Ethics: contextual, personal, fluid
Expectations: care about, attention to detail
Responsibility: responsive to
Taking care: respect, mutuality
Personal safety: feeling of belonging in bigger matrix
Nursing: gives energy - joy/pain

Figure 3. Image of Self as a Being in Relationship

Although some writers associate this type of relational matrix with a "feminine view of the world", the self and other do not carry specific gender roles per se. In the nurses' stories they often found it difficult to imagine persons devoid of the gender constructs but they often reaffirmed that it was "just how we are taught". The valuing of a contextual situatedness in this imagining of the world would permit a place for gender traits if they were perceived.

One might indeed make claims of other constellations of world views and images. However these are the two which seem to present themselves most in our deliberations together. Narratives often indicate that a nurse at any given moment was more positioned in one orientation than the other; however very often her world was the space in between. I reiterate Carolyn Heilbrun's (1990) description of how we imagine, and weave our own stories.

> We invent as we go along, support one another, and recognize, as we must, that our choice is as Florence Nightingale long ago told us, between pain and paralysis.
>
> One cannot make up stories; one can only retell in new ways the stories one has already heard (pp. 128, 129).

Retelling in New Ways: Response to Vocation

As a nurse educator I believe I am called by these stories to imagine a retelling of our lives as nurses in new ways. These voices call out to my person to respond to their declarations of life experiences. These narratives invite me to be present for their joys, their pains, their dreams. How could I not be personally changed in this hearing? The results of this inquiry compel me to examine my own position(s) as woman, as nurse, as educator. I perceive the levels of implications to be threefold. First how do these texts interact with my own text which inscribes my personal subject position? Secondly, how do the stories of these experiences in nursing influence how I assist other individuals who wish to become nurses or those who pursue further understandings of what it is to be a nurse? Finally, what are the consequences of these imaginings to the possibilities of nurses in the future? We are somewhat determined by the experiences of the person, the place and time in which we live but we are not over-determined. We have choices as we compose our lives. In the following sections I would like to explore how the listening and the speaking in this research inquiry has enabled me to envision new stories for myself, personally, as a nurse, and especially as a nurse educator. The understanding which is offered to me through the nurses' conversations is a call to wonder creatively in order to imagine - yes, to construct a world of nursing in harmony with our visions. This research emphasizes knowledge gained from reflection on the lived experience of nurses in their everyday practice. The rest of this chapter addresses ten areas of consideration which have been called to the forefront of my attention. Each section begins with a short discussion of nurse education or about learning to be a nurse, but note how comments allude back to the difficulty in living in the spaces between the constellation of themes.

I use these words, and the larger themes to which they allude, as a starting point for my own meditations. The process of this research has called me to think and act in new ways. These ten responses are my personal reply to that calling; I will expand on each one.

Be sensitive to language
Encounter multiple realities with equanimity
Explore preferred realities
Stay rooted in reflective practice
Write the marginal from personal centeredness
Choose person over persona
Embrace the responsibility of responsiveness
Learn to be present for myself
Respect the sacred
Never cease to wonder/wander

Be sensitive to language

Marie: *In our unit we are trying to monitor the patient care by doing quality QI's. The person in charge has to go around and* *check that all this is done. For example, dressing changes every day, IV dressing changes every day, you have to label that it's been changed, also that your cart in the room has been stocked and that the kardex is complete, with the information of the next of kin, height, weight ....*

Heather: *But that's not really a true reflection on nursing care! Do you think that is? I mean, it doesn't measure the time that you sat down with this patient for half an hour, maybe skipped your coffee break ....*

Marie: *I don't think that we will ever be able to measure that. I don't talk to many people about nursing situations. And that's kind of interesting. It doesn't seem to fit into discussions - to try to talk about it just doesn't give the idea of what actually occurred - I don't have the ability to do that.*

****

Sue: *I think that using a confident language shows my knowledge base. That I'm going on more than just an intuition. I would have factual evidence to back it up and I think the physician would respond to that more because they tend to be quite factual.*

Maybe it is even self esteem and everything else that goes along with that, knowing that I have a lot of things to offer people in the work place and that it was okay for me to speak up. I needed more of a knowledge base in a different way. I've started to find that in going back to school.

I hear the importance of language. It seems to be equally vital to acknowledge the limitation of (some) language and also to be able to choose a vocabulary and way of speaking which will ensure that what one has to say is valued.

Personally, these stories remind me to monitor my own speech and choose words with care so that I dialogue clearly and authentically.

Professionally, I am called to both challenge and encourage students and colleagues. We need to challenge the baffle-gab that sometimes poses as esoteric parlance in the erudite atmosphere of academe. But more importantly we must encourage and assist each other to articulate the difficult understandings we seek in our complex ambiguous world. We need to be fluent in describing both the scientific technological world and also that which is sacred and aesthetic. Hopefully, we will be able to expand on a variety of ways to communicate so that we will not get caught in the grasp of logical positivism and will be able to explore other methods of explication such as music, art and poetry. Needless to say we need to refine our skill at "really" listening as well as speaking clearly. In the future I intend to plan the curriculum that the students and I live in the classroom to include activities that explore and honor many languages. I hope to engage student and colleagues in intensive and open dialogue rather than taking a path of lesser involvement through passive agreement or the closure of censorship.

I sense that the situation in nursing today is not simply a multilingual diversity flowing from a variety of philosophical perspectives. I read between the lines that there is often a lack of consistency because of hazy images. If we believe that language creates as well as discloses the world, it is imperative that we 'take care' in our speaking of that world.

Encounter multiple realities with equanimity

Janet: *We made up a documentation sheet for our clinical conferences and then we also drew up a nursing care plan for our chronic patients. The responses that we got back from different nurses - some of them actually blackened the page and rewrote it ....*

Noella: *They crossed things out and were not constructive! I went to this one nurse. I wanted to know why she'd just destroyed all this work we did. Every time she gave me some excuse I'd look at her and kept asking her, "Why?" There's* *nothing wrong with what we've said there. Just because it's not your particular belief does not mean that this is wrong. We finally thrashed it out and she said, "I see where you're coming from now!" Then she did take the paper and she did a very nice job of recopying and filling in things that we had even missed. So, you know, I think it's just communication - it amazes me how I'll say something and somebody else picks it up totally different. But you have to be so careful and diplomatic because some of these people are in their Bachelor of Science program and they're doing all those research things and I guess they learn how to write these different things and they learn how to label them differently. And so that's where they were coming from! They say if this were in my class, this would never pass ....*

Janet: *You can see its language then. They see if the key words are there, if it is in, what is 'their language' now.*

Noella: *We said malnutrition, and what did she say? Nutritional insufficiency. And she said, well malnutrition is a medical diagnosis. Nutritional insufficiency is a nursing diagnosis. But we're saying it's all the same damn thing - feed the guy! We just wanted TPN or tube feed started. You know, after so many days, let's remember that. That was all we wanted them to say. So, in a way, it went from being a very negative thing to being a more positive thing, as we started talking to one another.*

****

Janet: *I don't totally accept everything because I know that some situations are going to be there, whether I accept it or not, it's not going to change how this physician deals with this kind of situation. It's just knowing that I can put things at bay and just keep going on. I find it's very hard because people don't realize the caring that you put into some* *situations and that value is only recognized by yourself and the people that are there at the time.*

I hear that nurses are often troubled by "difference". First of all they tend to take it "personally" which often evokes defensiveness and insecurity when one occupies a disadvantaged position. In this account they were able to confront (read: "stand facing; meet and look at" OED) their colleagues until each could "see where the other was coming from". In that way it turned out to be a positive thing. In the last paragraph we hear that at times one needs to be resigned, to keep going on, knowing that a certain view is only 'recognized' by a few.

Forgoing a claim to the God's eye view of the truth of grand theories often carries a sense of loss but it also has its advantages. Since we should be expecting multiple views it is incumbent on each of us to "stand facing and look at" other viewpoints. In the first case the nurses worked through the differences in language (and possibly more) and agreed on a mutual intent, "to feed the guy". However the win-win situation here was much more than finding a place of agreement, it was exercising the ability to stand facing and speak of one's position. This ability to confront did not find a mutually agreeable place in the last scenario but it ensured that one can put it at bay - not be devastated personally in the difference - and go on, knowing clearly what you stand for.

Personally, I am called to examine my own even-mindedness in the face of confrontation of difference. Do I have the integrity to receive confrontation and other's viewpoints without taking it personally?

It seems that it may be an occupational hazard of being a teacher, to think that one knows (or should know) the answer. How can I balance my need to stand up for my opinions and yet ensure that learners have adequate safe places to exercise their own confrontation of ideas? Is there a tone of respect for difference in classroom and clinical discussions? This is important not only between teacher and student but also among faculty, between students, and nurses with physicians, nurses with clients etc.

I hope to deliberately raise questions in the curriculum of difference and of strong yet respectful positions in responses. It will likely be necessary to raise to consciousness our usual gendered reactions to confrontation and provide a place to practice possible alternate responses to it.

Explore preferred realities

Noella: *The first time I went into nursing, they said, "Do this because this is the way we want you to do it." Sterile technique - I had it drilled into my head and everything was learned by rote. It was not reasoning and yet I went back to nursing 16 years later and everything was done by reasoning, not by rote. So the people that were coming out of this program didn't "know" sterile technique. They had an idea of what it was and they could understand what it was; but they had no sense that when you set up a tray, this is exactly the way it is set up. I think the whole system is starting to change. There's a lot more liberalism, a lot more input from the nursing level because I would have never thought to ever question anything sixteen years ago. Now, it just seems to be logical. Why not question it if it's wasting money, it's wasting time, or if it's not good for the patient. Let's do it a different way. Let's adapt a bit.*

****

Sue: *I remember the first time I felt that feeling of knowing things in a new way was in a nursing concepts course as a post RN and we just talked about what it was like to be a nurse. No one had ever really asked me what my experience was like being a nurse and how I felt. The opportunity had never been presented to me to think about it in that way. So one of the first things I can remember thinking is that things can change if we are willing to really partake in it and really take the steps to make things better for ourselves.*

> *For me the difference is in being able to articulate what you are feeling or what's going on instead of just getting angry in a work situation. For example, being able to say to a physician, I'm having problems with this because of this and this and this and having the knowledge, not just the knowledge of a good physiology knowledge but also the theory knowledge, to understand why you are doing what you are doing. A lot of times, I had run into difficulties when I didn't feel I was able to express myself.*

These stories illuminate three sets of changes that come about because nurses explored preferred realities. Noella experienced the 'revolution' in nursing (and curriculum) that exchanged rote learning to reasoned problem solving by using principles. Sue was awakened to the fact that she could change the future of nursing if she and others took action to make things better. She went on to say now she is learning to express the why of her ideas and feelings instead of just reacting. Each explanation develops a different plateau and promotes a reality of nursing that is more to the person's liking. In this example nurses first chose 'how' they would learn and practice nursing skills. Then came a realization that as the experienced actors in this arena of life's drama they might direct the course of their own actions toward preferred goals. Finally by living in these actions and through a reflective understanding of the "why" of praxis, nurses are being able to express themselves, not only reacting to others but in a proactive way, pursuing their own visions.

This may be most exciting of the creative aspects of being human - 'to pursue visions'. It is reported that when Einstein was once asked how he managed to have such brilliant ideas, he responded that he just had lots of ideas and only pursued the "good ones". Maybe the problem with many of us is that we do not cherish the flexibility and honor the courage to have "lots of ideas". This may be more limiting than the lack of wisdom to know which ones to pursue. One of the recurrent comments from the nurses during this study was "I never thought about that before" in response to views from their colleague.

Personally I wonder, do I explore the realm of possibilities enough or do I too often accept the taken-for-granted limitations?

Nursing curriculum seems to be in another stage of revolution (Bevis & Watson, 1989). One focus is on moving from rational problem solving onto critical thinking. As I see it one of major differences between the two approaches is what they regard as a starting place for the process. Problem solving gathers 'facts' more or less in the way they present themselves, and usually in the cognitive domain. Critical thinking asks us to explore the assumptions and political hegemony of the "facts". The data used for reflection are more often from a variety of sources. In the process the rational, contextual, syntactical and creative ground for the inquiry are all honored. This permits a vastly more far reaching exploration of our world.

What activities in the learning milieu of student nurses will promote this quality of reflection? When we went from 'rote to understanding' nurse educators talked about fostering the principles over the procedure. Maybe it is time to shift to increasing the valuing of a critical reflection over that of the best technical response. Our current curriculum often focuses on an appreciation of doing things that are efficient and effective, a coming up with the right answer. These qualities are rewarded through evaluation. The clear message is often that outcome is more important than process. What would happen if we also valued ontological and epistemological reflections on the process?

How would we convey the idea that being in touch, in tune with other human beings as valued for its own sake not just as it effects outcomes. Could the ethical attitude within the classroom or clinical situation reflect a sense of the importance of being embedded in life in a contextualized personal way? I presume this will only happen when we as nurse educators are able to model an egalitarian style of interaction that engenders the experience of an organic community instead of one of hierarchical power. This is the kind of atmosphere in which nurses would be able to imagine and explore the possibilities of preferred realities.

Stay rooted in reflective practice

Heather: *When I graduated from nursing in 1975 and when I first started practice, I probably really didn't see the patient. When you first start out you are overwhelmed by the rules and doing everything right and all the machinery and all the technology. As soon as you master all that and get some confidence, then you can see the patient as a real person and not just somebody you are doing something to. I think that ability is evolved from talking to the patient, talking to the families, hearing the questions they ask and the things they are concerned about.*

****

Noella: *Here's an example. My daughter Tammy is in nursing school and she had to do a nursing care plan on this lady and it was for nutrition. Nursing care plans just never made it with me. They make sense to me but not the way I had to do them. But she phoned me up the other day and she said, "my patient won't eat breakfast in the morning. She never eats breakfast in the morning so what should I do?" I said, "Just offer her what ever she wants - a cup of tea or something. She doesn't have to have a full breakfast just because she's in the hospital. Tell her you can probably offer her a piece of toast maybe at 10 o'clock in the morning. You are a student nurse, you have lots of time, you are catering to one patient and she's not a very ill patient." So she wrote that on her care plan. Well, she was marked wrong and they wanted to know who did she get that information from. She said, "My mother's a nurse and she's worked in a hospital for eight years and she said that that would be a logical thing to do." Well, the nurse teacher down there said, "No, the patient must*

> *eat!" And Tammy said, "Well, let's phone a dietitian." So they called the dietitian and she said exactly the same thing that I said. Don't force her to eat if she's not used to it. Feed her later or just tell her the options. She can either eat now or she can eat at lunch time or she can have her husband bring her in a little something half way through the morning. But they would not accept that!*

Noella's story may speak of the extreme case but nurse educators are often accused of living in ivory towers and not in the 'real' world. Heather's recollection of her nursing being technically focused in the first years after graduation is a common report from many nurses. What might be some of the underlying factors in these perceptions? Are young nurses overwhelmed by the rules because they are marked wrong when they seek out advice that is 'logical' in practice or evolves from talking to the patients, listening to their concerns. How do we as nurse educators value the practical, reflective wisdom of praxis?

We are very enthusiastic in promoting research utilization. We mandate the incorporation of theory into practice. These are indeed worthy goals. However we are much more reticent about embracing the thoughtful knowledge of experience. Often I sense that we fail to acknowledge that this understanding is a different kind of knowledge. And if we do appreciate that fact we relegate it to that which must be learned after the formal nurse education period. We also are frequently adamant that practicing nurses who choose to return to university, set aside these understanding and take on a more 'scholarly' approach - leaving behind their 'second-rate' comprehensions.

These narratives evoke in me a desire to be personally vigilant in showing a balanced respect for a variety of different ways of knowing. This stance may be comparable to what Belenky et al. (1986) call 'constructed knowing' which is a process

> of weaving together the strands of rational and emotive thought and of the integrating of objective and subjective knowing (p. 134).

> Most of the women we interviewed were drawn to the sort of knowledge that emerges from firsthand observation and most of the educational institutions they attended emphasized abstract 'out-of context-learning' (p. 200).
>
> Teachers, as well as students, yearn for an atmosphere less academic and more intellectual, but the teachers are unable to reduce the pressures and the students are unable to resist it ... (p. 208).

Belenky and her co-researchers propose that we adopt a process of 'connected teaching' which along with other issues "accords respect to and allows time for the knowledge that emerges from firsthand experience ... encourage(ing) students to evolve their own patterns of work based on the problems they are pursuing" (p. 129). This is what these nurses are telling us they do after they leave the education setting. This is what Patricia Benner (1984) is focusing on when she reflects on the realities of practice. Benner proposes that knowledge embedded in practice is indispensable for attaining nursing expertise. How can I as a nurse educator bring the realities of practice, the realities of living into our classroom? One of the possible approaches would be to include the narratives of the students and of other nurses in order to better understand how we weave our nursing lives.

Write the marginal from a personal centeredness

Shauna: *My degree helped me get all over the place. I did a posting in an ICU, and afterwards, one of our classmates said, "You should go and work there and maybe that will give them your attitude which might help them see the patients as people." I'd love to go there and say "Yeah, I am going to go out there and change the world, but I'm afraid that the world will change me!"*

Sandy: *Maybe the challenge would be just to remain the same. Remain healthy, strong.*

Terri: *Because that happens all the time. You are the new grad - you're the new person coming in - you have a new attitude, the challenge is to change them rather than them change you.*

Shauna: *"Graditis", when you first come in, that's the medical term for it, you're sick in some way, "You have graditis"....*

Chris: *My experience hasn't been a negative one in sort of just waiting it out. I think I did my thing and what happened was that I brought people on my side. I think that very quietly that's what ended up happening. If you think about the people you work with, they might say, "Oh, this is a really hard nosed nurse". Well, that was true, we didn't always see eye to eye on things, but I felt comfortable with those people and so, maybe what I did was that I kept on being a role model.*

Sandy: *Often it isn't something that you are aware that you are doing different or even aware that you have a varied point of view. But you're heads and shoulders above some of the other people who have never given it any thought and don't question why.*

This discussion explores what we as nurses do with our idealism when our personal visions do not fit in with the mainstream images. Shauna, a recent graduate, is eager to share her attitudes for more personalized patient care yet she is labelled 'sick with graditis' so that her peers can cure her back to 'normalcy'. One option is for the nurse to just hold her own - to remain healthy and strong (an interesting contrast in metaphor). Chris, a very seasoned nurse, says she has had positive experiences in quietly waiting it out and that as a role model she can sometimes bring others 'on side'. Sandy reminds us that even if it is at an unconscious level, what is required is that we live everyday with a vision of what might be possible. What gives these nurses courage and comfort to meet the challenge of being true to themselves when they meet other nurses with whom they don't always see eye to eye?

On a personal level I wonder do I always exhibit the 'intestinal fortitude' to take positions that are not in the mainstream. Are there times I'm hesitant to venture out of a comfortable closet of acceptability to voice an alternate viewpoint? In the discussion above, the advocacy of more personalized patient care hardly raises an eyebrow of most nurses and nurse educators. But sometimes the position we might feel compelled to stand for is viewed as more marginal. A popular use of the idea of "margin" by some postmodern writers draws attention to the fact that the thoughts expressed in the margin are a response or an addition to the authorized text and often in tension with the official text.

Recently at a university convocation, a graduate of a baccalaureate program for nurses and the recipient of the faculty's gold medal for highest academic standing, chose to make a statement that caused a great deal of discomfort to many of her classmates and most of the faculty. During her undergraduate years she had experiences and evidence which led her to believe that the university at large was engaging in unjust and oppressive research, policy and practices. At the commencement ceremony she wore a placard which stated that this university stands for 3R's; Racism, Rushton and Repression and that she was ashamed to be a graduate! There was a gasp and hushed whispers from the thousands in attendance and a lot of soul searching and reflection on the part of the faculty. We had spent several years encouraging these graduates to endorse principled action. We tried to engage them in reflective dialogue in order that they might develop their own ethical voice. We sought to help them acquire the wisdom of the 'bigger picture' of life. Had we failed or was this a testimony to the embodiment of those values? We might not each personally share the message and/or the way it was delivered but there was no doubt that this individual had a great deal of personal courage to literally write her convictions in the margins from a position of centeredness.

Hopefully this action, which was for many faculty a painful success, will provide us with courage by example to ensure that there is space in our lived curriculum for dissent. Maybe we will increase our understandings by both reading and writing in the margins.

Choose person over persona

Shauna: *I guess that I have been taught that to be therapeutic is to be objective. In basic training, you are objective when* *you reflect and you use "F9 statements". That is how you do it, that is how I was taught.*

Sandy: *I look at it differently now; for some of us that view is a little bit alien. We are looking at the situation and using totally different skills. There were certain things in communication class that they said were not therapeutic responses but I don't know because I get pretty good results with some of them.*

Chris: *It's supposed to be blocking to use your head and I'm a head nodder.*

Sandy: *Yes, me too. And there were other examples that were alien to me in the sense that I was having to not only learn the skills but look at what I had been doing in terms of things that had been working and things that don't work. I'd think, "Hey, wait a minute, my experience tells me something different!"*

Shauna: *I wonder why was "therapeutic" so foreign? Before the classes I felt like I was therapeutic and it didn't feel so uncomfortable.*

Sandy: *Yes, uncomfortable and not me - maybe that's just it. It's almost like you are trying something out.*

Shauna: *I think maybe you need to be a combination of this 'objective-therapeutic' and yourself. It's a judgement call, as things are going along, you decide where you are going to be therapeutic objective or you yourself.*

Chris: *And sometimes you go back and forth. So I'm not sure that I always want to be therapeutic. I'm not sure.*

Sandy: *'Therapeutic' in the strict sense.*

Chris: *Yes.*

****

Terri: *At the time of my first entry into the hospital world, a senior person warned me, never to become involved*

> *emotionally with people because it would be the ruin of you: because you couldn't bear to expend that energy; because it would really pull from you and you couldn't apply yourself professionally; so I was always cautious at that time.*
>
> *But later on I just thought, "My goodness, I can't do this any more." I have to throw it all to the wind and many of those people are now my friends because they weren't just patients, they weren't just people I cared for, they were people I truly cared for. I'm very close with some of them. I am meaning yes, they are people we care for in a professional way, like we apply our nursing skills, but yet I'm saying, I have to take that word back to its origin because I care for them with my heart.*

What does it mean as a nurse to be therapeutic or to give professional care? This conversation would suggest that nurses in practice do not always keep the same definitions that they were offered in their educational experience. Again we see a valuing of praxis and the development of a practical wisdom of what works. But I also hear a more profound rejection of the desirably to take on a therapeutic professional mask. I sense they are opting in favor of a more authentic presentation of self to the other. This somehow enables the type of 'care' they seek to engage in, a care which is based on mutuality and respect.

I wonder, how often do I take refuge, mentally or in my actions, in maintaining my professional role as professor? If I seek personal safety in keeping the authority and proper distance of that role it certainly does not promote the sense that the students and I are in these educational pursuits together. It is no wonder nurse educators would avoid cognitive dissonance, by proscribing a professional distance for their students.

Possibly these nurses' accounts are a call to abdicate the throne of professional privilege, to give up the exalted position of objectivity, to come down and live with/as fellow human beings - teachers with students, nurses with patients. Does this endorsement of our fellowship reject the responsibility of leadership? I think not. Acknowledging the common ties of the kinship of 'persons' strengthens our ability to communicate more fully, to understand ourselves and each other in this bigger matrix.

This can be experienced in the classroom through more egalitarian processes, negotiated goals and shared values in evaluation. It is probably observed most clearly in the subtlety of language in dialogue. The royal "we" dissolves into multiple "I"s.

Embrace the responsibility of responsiveness

Nancy: *The inservice staff educator was there with you during orientation. You would buddy with somebody else but she was always there in the background making sure that you weren't being left hanging; or if you got sent for something, she'd go and help you get it ready. She was there until you had developed that rapport with the other staff so that you weren't feeling intimidated.*

****

Sue: *If people needed me to be there with them while they were grieving, I was the kind of person that it was okay to be with. I was a safe person to cry with or talk with or share the memories. Professionally too, I hope that the little time I've spent with someone, they would feel that if they had that need, it doesn't scare me to spend time with families doing that. I feel like it's really a privilege to be part of that with people. It's sad but there's something okay about it.*

I never learned how to be there for people in nursing school. You can learn how to care for people, how to listen to people and respond. I took one course last year - a communication course on responses and it was really good. We did a video tape. We had to look at ourselves, talking to someone else with a problem. I was very silent during the interview. I didn't say a lot of things because I didn't feel *it was appropriate in that situation. If I were a patient, I'd think it's part of a nurse's job. I just wouldn't expect a nurse to put a little bandaid on my thumb and say, "Well come back in a week and get the stitches out." Anybody can do that. Just kind of makes it so technician-like; so maybe learning how to care should be a part of a nurse's education.*

****

Marie: *I see university as more self-study and I learn a lot better with an instructor in front of me. Therefore, if I could get my degree through college, I would be more interested than going to university because university has always scared me. I feel there's less personal relationship at the university. You might have a relationship with friends but with the instructors and the faculty the relationship is very distant and that has always turned me off from applying there.*

These three accounts speak of the importance of responsive relationships in nurse education. Nancy's inservice educator was there for her, in the background so she could learn and develop rapport (read: to carry one through a harmonious communication, OED) so that she would not be left hanging or feel intimidated (read: awed by fear to control behavior, OED). Although Sue didn't learn how to be there for others in nursing school, patients find her a safe person to cry with, talk with and share with. She finds those encounters a privilege and not scary. Since being a nurse is much more than being a technician, nursing education should address listening, responding and appropriate silences. Marie learns better face to face and the prospect of only "distant" relationships scares her and turns her away from educational goals. Three stories that suggest a tension between fear/safety and the rapport of being there with others.

A fourth year student in a BSN program and the president of the local chapter of the Canadian Nursing Students Association presented an invited address entitled "Empowerment, a Future Goal for Nursing" to the

1993 National Conference of that organization. The student, Lorena Iachetta, gave permission to include her voice as she offered a reflective paper on the experience of preparing and presenting that address. Here are excerpts from that paper.

> The phone rings. I have been selected to present my paper at the CNSA National Conference. Again the feelings of fear, insecurity ... but in reality it is the fear of acceptance, I know I can do it, but will my peers accept it?
>
> I have been empowered by the many interactions throughout my nursing education. I have been nurtured by my peers, my family and professors. I chose the topic of empowerment because I had something important to say and to share with others. The preparation was complete and it was time to come before my peers. Again fear.
>
> As I stood at the podium, I felt a sense of security, I couldn't explain it, the environment was an accepting one. The fear was gone .... The presentation is over and discussion started. Reflections on the comments from the delegates on situations that they had felt powerless in, were rooted in the common theme of feeling afraid ... the quivering voices, the silences, the stories spoke volumes. Somehow I felt I had reached someone ... we had come together in a common goal: nurses discovering themselves. I will be forever grateful to the faculty who have helped me find the wings to fly and for lighting the path to a freedom from fear.
>
> (Iachetta, 1993)

We must embrace the responsibility to be responsive to our students, our patients, our colleagues, ourselves. We must create safe places to be together.

Learn to be present for myself

Chris: *Care is like being with, and it's about being, an expression of being.*

Sandy: *It's about respect.*

Shauna: *The words that you use to describe "care" - are they the same things that you were looking for in your students?*

Chris: *Yeah.*

Shauna: *There's something else that Sandy said about comfort when you were talking about comforting her. I was just thinking about the nurses that you picked out. That you thought would be good nurses because they took the kleenex and cried openly at the movie. They wouldn't be comfortable doing anything else. Maybe that's the same thing that you were* *looking for, and it makes what you call a 'good nurse'.*

Chris: *It's a natural thing. If a student didn't have those characteristics and she'd say "Chris, make me a nurse." I'd say, "I can't tell you how to be like that." I mean I don't know but I guess I think there's an instinctive characteristic about it .... (pause) You know how I think we teach that? I think we do it by role modelling. As a teacher, to some extent I help students with what to say to explain their activities with the patient, but how they say what they say I think I teach that by role modelling.*

****

Heather: *It's sort of inculcated through training that the last person you think of is yourself and so you're always meeting the patient's needs or the family's needs or the doctor's needs or the head nurse's needs!*

Sue: *You know what would be a help is if during our education, we could just explore our own feelings and being really comfortable in dealing with those feelings. How can you be there for somebody else when you are not there for yourself? I remember in the post conferences we had "so what did you do good and what did you do bad?" and I don't remember dwelling on how I felt about it. I'd never seen a sick person before and how I felt about that. "Did I do catheter care right," not how did I feel about doing that. It's not always comfortable to deal with that either. I mean, how do you get up and give a lecture on it, how would you make it meaningful?*

****

Maureen: *It's hard to know when you're safe emotionally to be connected with a patient and when you need to distance. I think it depends what else is going on in your life. If you have the energy to really get emotionally involved.*

Nancy: *Well, yes, and also what's been happening at work. If the week before you've just been through hell, you're just not ready to invest yourself ....*

Maureen: *You just can't do it again.*

Nancy: *So it has a lot to do with whether you feel you can invest or give that much of yourself and still protect yourself. There's times when your energy's high and you can do it and there's times your energy's low and you know it's going to take too much out of you.*

Chris starts out "care is like being with ... an expression of being". It would be fruitless to offer a course "Being 101" (you can't give a lecture on it) - it's a human "natural thing" and we help others develop their own way of being in the world by role modelling ours. Heather and Sue report that although they didn't experience this in their own 'training' what might be helpful would be to explore one's own feelings and become comfortable (read: become strong with; relief in affliction, OED) with those feelings. They ask how can we be there for others when we are not there for ourselves? Maureen and Nancy tell us that throughout their nursing practice it is important to consistently be in touch with your own level of energy in order to be able to be safe; protect yourself and yet be able to get involved, invest and give of yourself. Invest is a significant word here because it suggests the giving and receiving back that was often present in the nurses' stories.

However, is the inclination to give too much, to meet everyone else's needs and ignore your own sometimes valorized in image of the 'selfless' dedicated nurse? Is this stereotype supported by the gendered traits inherent in the good mother, devoted wife and dutiful daughter? These truly are 'self-less'; the self in those images is merely instrumental. How do we as nurse educators assist nurses with that ability to be strong and discerning of that energy which flows from an understanding of how one is embedded in life?

I sense that it starts by getting in touch with our own being - our feelings, our afflictions, our desires and 'comfort' ourselves that we are 'okay'. If traumatic experiences have left us as 'the walking wounded' how can we assist others to grow and heal? In today's psychological vernacular it probably means getting in touch with and 'doing your own work'. How else can we role model a way of being that is helpful to others?

In addition I think extensive possibilities can be opened to students by inviting, permitting, and providing the space for them to explore their feelings as well as their thoughts. And although these insights are not conducive to lecture, they can be facilitated through discussions, journals, questions and a nonjudgemental respectful listening.

In this study many narratives spoke of how nurses anguish in fear, insecurity, self-doubt and a frenetic trying to please others. Much of this affliction could be alleviated if we as nurse educators could assist our students to learn to be aware of their own experiences and of how to be there for themselves. But it seems that 'being' present begins with self.

Respect the sacred

Noella: *I remember being in the ambulance one time when I was very new at this. The driver of the ambulance was an EMT and he also was the youth minister at our church and he was a "real kind of guy". I was losing the patient that we were bringing in and I said to him, "What do I do? He's going to die!" "How do I keep the life in this body - it's up to me to keep this life." He said something that just kind of knocked me back on my feet. It was, "It's not you that holds the keys to life and death; it's God." That took such a weight off of me that now when I deal in any emergency situation, I don't have to worry about keeping the patient alive. I just have to worry about doing my job the best I know how.*

****

Heather: *It was my first year of nurses training. This gentleman was brought in. He was end-stage COPD (a chronic debilitating lung disease) and he was dying. They didn't have any beds so he was put in the treatment room. He had no family with him and he was wide awake and he was sitting bolt upright in bed. He was purple and his eyes were bulging and all the veins were bulging in his neck because he was just straining to breath. He had nobody with him and the look - he had just such desperation - the look in his eyes - that's 20 years ago and I can remember exactly what he looked like. I was working evenings and I remember that every minute I could I would go in and sit with him for a while and hold his hand. I should have just told the other nurses that I was going to stay in there with him, but I was a brand new student and I thought I had to go and do the work so I'd go and do a bath or whatever and then go run and sit with him.*

I remember when I first became a nurse and I was dealing with somebody whose relative was dying and I never knew what to say. I was only 19 or 20 years old. I don't know that I had settled my own feelings and decided what my philosophy of death was and here I'm supposed to help somebody else! Then as you get older, you realize that there isn't a magic phrase to say. It's just giving the other person an opportunity to say what they want and being comfortable with death and dealing with people who are upset.

****

Nancy: *I think to a large extent that spirituality has left the health care system. When I was in nursing school, you routinely asked a patient on admission, of their religious affiliation and did they want the pastor to visit them when they were in the hospital. Now we only seem to do it if it's* *a critical situation and even then, some nurses aren't comfortable doing it any more. It's almost like in our society that spirituality in the traditional sense is something to be ashamed of. I remember when we first developed nursing histories, there was a lot of discussion whether it was proper to have it on the nursing history forms. Was it an invasion of some kind of privacy?*

Maureen: *In the neuro unit, we get a lot of native indians and they always want to burn their sweet grass and we can't let them do that, especially if there's a ventilator attached to the person. But we encourage them to bring it in and we've actually sent lots of people down to the morgue, holding their sweet grass.*

****

Sue: *I think it's a real privilege to be part of the happy things of people like when a father comes in and sees his new born baby. I will always feel emotional when that happens - like he touches the little finger and it's just so beautiful! I always get real choked up and I just rush over to say, "Do you want to hold the baby?" or "It's okay to kiss her." It's just wonderful to be part of that and I'd never be part of that if I was doing something else. It is sharing their joy and their sorrow but sometimes it's really hard too. Those are the things that keep me going back. Those are the reasons why I'd say to someone, "Yes, become a nurses; be a good nurse because good nurses are excellent; don't be a bad nurse because there's no room for those."*

This series offer accounts from the front lines of nurses' encounters with the sacred. Noella was 'knocked back on her feet' with the realization that she did not hold the keys to life. Once we give up the delusion that we hold up the weight of the world, we can stand up in difficult situations. Heather carries a regret for over 20 years that she had no language. She felt there was no way of telling the other nurses that it was more important to be with this desperate dying man than to go about the tasks of her nursing duties. It is interesting that Nancy and Maureen recognized that in today's society (and the health care system) both patients and nurses are often ashamed of their spirituality and are concerned about invasion of privacy. Yet it seems that it is more okay to be cross-culturally accepting of a native person holding sweet grass than someone finding solace in a bible or a rosary. Sue reminds us what a privilege it is to be present for the mysteries of birth and death. And that this is what keeps her in nursing - the calling to be an excellent nurse because there isn't room for anything else.

Sue is not the only one choked up when encountering such joy and sorrow. As a nurse educator I am humbled and stand in awe at my own calling to be part of individual lives as they 'become' nurses. They remind us that neither we nor our planned curriculum are the key to that 'becoming' but we can only do the best job possible to assist them on their journey. This may well include helping bring to expression that which often borders on the ineffable. We are challenged to demonstrate in our actions an honor for the sacred in our own lives and a visible regard for the spirituality of others. The limitations of the language of education and health care today make it so easy to render the sacred invisible. We are called to make our visions whole again.

Never cease to wonder/wander

I do not start this last section with an example from the narratives of the nurses because I consider all of the previous quotations to be a compelling testimony. They have offered us the wisdom of their insights. They have entreated us to explore new possibilities with them. They have challenged us to reflect upon the images of ourselves we choose to take into the future in our relationships with others in our professional practice.

CHAPTER VI

EPILOGUE: RE/MEMBERING WITH NURSES

An epilogue is the final part of a literary work that sums up or concludes. This is the position in which I perceive myself, however the work of this inquiry is not really over. It seems nevertheless to be an appropriate point in time to comment on the process of this research. The purpose of this last chapter is to reflect both on the experience of doing this research and how this research speaks to the context of curriculum-as-lived in nursing education.

The Experience of This Journey

I say that the work of this inquiry is not really over because in talking with the nurses who joined me in the production of this text, there is a sense that both the stories we have shared and the exploration of meanings which began in our discussions, continue even now in our lives. Our experiences together have provided additional vantage points from which to view our lives as we listen to the echoes of discerning voices. These understandings continue to inform us as we compose our lives. Mary Catherine Bateson (1989) reminds us that the art of improvising our life as a work in progress involves

> recombining partly familiar materials in new ways, often in ways especially sensitive to context, interaction and response. (p. 2)
>
> Women today read and write biographies to gain perspective on their own lives. Each reading provides a dialogue of comparison and recognition, a process of memory and articulation that makes one's own experience available as a lens of empathy. (p. 5)
>
> What are the possible transfers of learning when life is a collage ...? What insights arise from the experience of multiplicity and ambiguity? These are important questions in a world in which we are all increasingly strangers and sojourners. (p. 10)

One aspect of this journey which was especially perplexing for me was the question of whose voice(s) was(were) producing the text? I initially sought refuge in the metaphor of chorus but later found the word problematic, it seemed much too naive. I worried that it did not sufficiently allude to the dynamics among the 'singers' nor to my position of power as the 'choir master'. This area became a focus of more concern both in response to discussions with academic colleagues concerned with possible research bias and also from my own gendered response to others in not wanting to be assertive or directive in the process.

It was the dialogic process itself that led me to other plateau of understanding. The nurse participants had no problem at all with the idea of multiple voices. As we got into our discussions they helped me to understand how this was possible. Very early in our meetings, our time together took on the qualities of 'Beings in relationship' - although none of us would have had that label for it at that time. "Voice" was not problematized in the egalitarian interactions of an organic community. Dynamic autonomy imbedded in a contextual matrix with others was not a contradiction. Ownership of a unique voice was a non-issue; of course it was unique and of course it was connected. Ambiguity was not the disadvantage of obscurity but the advantage of multiple meanings. My responsibility was not the power to control or support but the call to be responsive to our conversations. It is easy to say "of course" in hindsight. Many of the participants have described an experience of growth, joy and comfort in being part of this inquiry. The following are some comments from the participants that represent the general tone of response when they read the draft of this text.

> I am very impressed with the work that you sent and find it fascinating. I read your findings and find myself nodding my head and saying 'Yes, she has hit the nail on the head, that is exactly what it is like, or what I was meaning.'
>
> (Heather)

****

> I am very glad to see our sessions in "print". I wonder ... will the communication, rapport and ongoing liaison improve in the future if dissertations similar to yours are put in the hands of medical staff? Where will nursing end up? How much impact will we as nurses have with those issues we discussed? Thanks for being the avenue for these discussions.
>
> (Janet)

****

> When reading the parts of your dissertation one of my first thoughts was that nurses have so much to negotiate in their work lives. Our responsibility is great ... I enjoyed participating in this study!
>
> (Sue)

****

> I was quite intrigued to see how you made connections and saw themes in your work. The themes and your interpretations of the nurses stories all seemed to fit for me. I marvel at how much work it must have taken for you to tease out the themes and recognize the commonalities in the stories. I look forward to reading the finished product.
>
> (Sandy)

****

> It is so interesting to read the narratives. It confirms what many colleagues express; nurses suffer/endure/experience what no other discipline does. The narratives are excellent! I feel as though you are writing about me (one nurse in a million); the feelings, thoughts, fears, frustrations, happiness and "perks" in a professional and personal context. Thank you for the opportunity to be a small part, this experience has been rewarding for me.
>
> (Terri)

As others began to read this text, I was intrigued by the diversity of responses. Nurses, especially nurses involved primarily in patient care, often responded very positively to the reading of other nurses stories, expressing a sense of kinship with the meanings delineated in the discussions. However, some individuals, particularly non-nurses and/or those from the academic community were less at ease with the format and content of the text. Although their concerns were expressed in slightly different ways, it seems there was a difficulty in perceiving 'the point' of the research. Some even found it confusing or boring. I take this range of responses very seriously. How do these variations inform me in future research endeavours? In what ways do previous experiences and personal subject positions enable/limit the reading of others lives and the understandings of those lives?

I have a sense that there is more here than is first apparent. A nonreceptive or critical reading might be partially rooted in a devaluing of interpretive experiential knowing; but this did not always seem to be the case. Another explanation might be the absence of a certain tacit "cultural understandings" involved in nursing.

A philosopher colleague recently stated that she perceived that the philosophical view that might closely fit with this inquiry was one which is clearly explicated in Buddhism. Her underlying concern was that the nihilism and unmitigated relativism of the skeptical postmodernists did not fit this research; I wholeheartedly agreed. She outlined that in Buddhism

> all knowledge is perspectival; ... all reality is a process of interacting conditions. The point of developing mindfulness is to let go of hanging onto things as though they remain the same. Identity is a matter of processing perceptions as one participates in what is actually there.... Ontology and epistemology are inseparable from each other in this perspective.
>
> (Tomm, 1993)

These comments may offer some possible insights on why the variety of readings of the nurses' narratives.

It is the rare nurse in North America who would articulate her philosophy to be Buddhist, however, I believe from my experience of living in the world of nurses, most would not find these views 'foreign'. They would describe being in touch with a world that is changeable and hard to put into words and that "being there" is to be responsive and respectful. For them "knowing about" and "being in tune with" what is real is intrinsically intertwined. In addition nursing practice incorporates responses or goals based on values; clearly normative in nature (which is also consistent with the Buddhist view).

In his recent article *Aspects of "Reality" and Ways of Knowing in Nursing: In Search of an Integrating Paradigm*, John Wolfer (1993) explores the types of knowledge, theory and research needed in a practice-oriented discipline. I believe the conversations in the previous chapters demonstrate that many nurses in practice often already have this paradigm. Our "search" needs to take us into conversations with our practice colleagues! Perhaps it is the position of being embedded in practice that engenders certain cultural understandings that permit an integrating paradigm.

Paul Ricoeur (1973/1981) states "that the text is the medium through which we understand ourselves." This subjectivity is not given only in the situation of discourse, it is created or instituted by the work itself. This is an "appropriation" of the text and its application to the present situation of the reader. "It is not a question of imposing upon the text our finite capacity of understanding, but of exposing ourselves to the text and receiving from it an enlarged self" (p. 143).

Sandy, one of the participants commented in a recent letter, "You might find it interesting that I wrote my self-introduction before I read what you had written about the significance of how the nurse imagines herself and knowing where she is coming from." She went on to say that the text "Once again echoes of something I need to pay attention to, for myself." I believe these "echoes for myself," and Ricoeur's "receiving from it an enlarged self" are similar. The significance of this research may be understood as the ability of individual nurses to hear the reflective voices of their colleagues and receive from that experience an enlarged self, a better understanding of how they stand in life.

Are the nurses able to appropriate the text more readily because of a tacit knowledge or understanding which parallels Buddhist views of reality? Is there something about their life as nurses which promotes the development of a mindfulness, through participating in the process of interacting conditions? What permits us as individuals to expose ourselves to a certain text? These questions directly impact on the issue of validity, or how generalizable this research is to other populations. As a nurse, a nurse educator and a researcher, I have a notion that these questions and their possible responses will pursue me for a long time.

Re/Membering Life as a Nurse/Teacher

I will speak now about how this research calls me to think about and respond to my life as a nurse/teacher. Because I have heard the voices of these nurses I am able to compare and re-member my own renewed imagination of what is possible. The context of my current subject position is that of university professor in a faculty of nursing, working with baccalaureate and graduate students. I am called to think about choices within this work life in a way that has been informed by this inquiry.

As I think back across the journey of this research, the voices of the nurses in our many encounters and in multitudinous conversations come to my ears. In the research process I have relived these moments through the repeated playing of our video tapes. I have watched with care as the individual stories, phrases, and sense making distilled onto the printed pages of this text. I now wish to arc back across the polyphony of those narratives. I use the lens of those stories to focus on the reflections from the story of Mary and the experiences in my own practice which initiated this pilgrimage. I revisit those reflections as a person who has been changed through the process of being exposed to the text of our search, having received from it an enlarged self. The themes from this research speak to my current life with students and colleagues imbedded in a nursing curriculum. I engage my reflective voice of the past with my current understandings.

The roots of nursing

In Chapter I - Remembering with Mary, I questioned the experience of being a nurse in an intensive care unit. I wondered if the technological gift of "scientific certainty" was a blessing. The purpose of that kind of unit was thought by many to be the saving of lives. The cardiologists and the cardiology nurses spent years refining their knowledge and skills to apply the 'cutting edge' of technological advances to patients. We were conditioned like fire horses to respond to the sound of the bell and the smell of danger. Yet there was nothing in our state of the art medical magic that would significantly change the outcome of that day for Mary. That experience challenged me to take a new and critical look at what we were doing. I had chosen to "return to my roots in order to rekindle a passion." What "roots of nursing" did I seek?

I continue to wonder about the experience of being a nurse, now in the context of a nurse/professor in a university faculty of nursing.

Do I now profess or lay claim to the gift of academic wisdom, since the purpose of this kind of institution is thought by many to be the bestowing of knowledge. The parallel for me is alarming. As educators and researchers we spend years refining our knowledge and skills to convey the cutting edge of nursing to our students. We are conditioned to scrutinize the scholarly references, checking academic genealogies, critiquing the conceptual clarity of our frameworks. However, I wonder, what is there in our state of the art academic magic that will significantly change the outcome in the daily lives of nurses?

The voices of the nurses tell me they believe the roots of their professional practice that gives them stability and nourishment are found in personal relationships embedded in practice. It is the being in touch, intune, the making a difference in another's life that enkindles a passion in their work.

Today, as on that Sunday morning several years ago I am challenged to take a renewed critical look at what we are doing. How does the curriculum I live with the students honor the roots of personal relationship?

Encounter

At the center of Mary's story was a wondering about the experience of recognizing an Other. From the first moment of our encounter there was something about her person that came out to me, some recognition, some mutually though silently acknowledged kinship. What permits us this "recognition"?

Through this inquiry nurses tell us that the experience of encounter that they value is that of belonging in the bigger matrix of an organic community. These egalitarian relationships are characterized by the sense of a dynamic autonomy[1] which is connected to the other and yet not constrained by dependence. They desire a sense of self that is both differentiated from and related to others. They speak of others as subjects with whom one shares enough to allow for recognition of their independent interests and feelings.

---

[1] As noted in earlier parts of this work the use of this phrase is consistent with the meaning described by Fox-Keller (1985).

How do I now role model or foster in myself and others the capacity to receive another face to face? Does nurse education lead us out *(L. educare)* to recognize the other in dialogue or does it often lead us into a soliloquy in the confined safety of nursing's prescriptions and frames of reference.

Response

I wondered what enabled me to respond to an Other? I questioned how I found myself assigned to that part of life's play. I felt myself to be ad-libbing the way I was present. What prompted my desire to insert those particular lines in that special experience? Al was initially stunned into a voiceless helplessness. However, he regained his speech to talk of life shared with Mary, to speak of a warm and vibrant woman. He remembered, put together again, what was essential in their presence to each other.

In the context of nurses' education, how might we respond to an Other in our professional lives? The nurses' narratives clearly articulate a preference for interactions which are respectful, mutual, and responsive to the 'person' of the other.

It is difficult to reciprocate in a reply to students and colleagues that is mindful of respect and honor when we are immersed in a patriarchal institution. Academe 'cares' for its members through control/support; the members in turn have the duty to conform to its rules. This ranges from the dictates of Senate rule to the dogma of the Canonical Texts. Is it possible to regain our speech to talk of our shared life - to put together again what is essential in our presence with each other? Do we ad lib the script or can there be some deep re-membering from reflective practice? from being human?

Embodied caring

In the experiences with Mary caring was embodied. We formed a fellowship of caring; Mary, Al, Susan, Linda and myself. That day we five shared in this dance, this engagement. "Care" originally meant to "mourn over a bed of trouble or sickness." As I look back to that day I see that our fellowship journeyed through the lived-meanings of "care" in a way that paralleled the lexical definitions:

- to be troubled, uneasy or anxious...
- to take thought for, provide for and look after...
- to have a regard or liking for, as worthwhile...
- to have a fondness or attachment.

This mourning/attachment was corporally incarnate. We danced the patterned movements of this care in flesh and blood upon the earth. Tears and laughter were evidence of embodied spirits. This shared ministering took multiform concrete expressions.

Our engagement of care with each other in the lived-curriculum often journeys from mourning over a bed of trouble to a fondness or liking and back again! In the context of nurses' education this mourning/attachment are also corporally incarnate. However we are disadvantaged in comparison to the practice setting. Our world of the curriculum magnifies the importance of the life of the mind to such an extent that bodies are often perceived as that vulnerable, service-oriented part of the human being which merely carries around the head to do the important work.

The voices from practice speak of an embodied 'caring about' which attends to the detail of the other. Shared ministerings are contextual, personal and fluid. How might we 'come to our senses' within the halls of higher learning? The body-mind schism must be reunited before nursing as 'healing' will emerge from this professional preparation.

The space between

Mary helped me to understand a living/dying in the space between a technological world and a world of being? While we were embedded in an idiosyncratic, ambiguous, human condition, we also stood in the midst of a logical, orderly, predictable, technological world. It was an opportunity to find strength in the coming together of those pluralistic realities.

The recurrent themes in this research speak of the multiple realities and diverse perspectives surrounding the nurse in her everyday life of practice. The nurses tell us that although this pluralism is often problematic they would not wish to simplify their worlds by outlawing conflicting perspectives. They see an opportunity for a comfort, a space to find strength in the coming together of the sacred with the secular; the humane and the technical; the material and the ineffable.

It is in contemplating this aspect of our situation in which I find myself dizzy with possibilities. It is in this goal of sharing a better understanding of the *materia nutrix* that is the *raison d'etre* for nursing education, nursing research and ultimately nursing practice. This multiform root must be nurtured in its complexity and diversity if nursing is to flower.

In celebration

In sharing that day with Mary, those of us at her bedside were able to honor, to observe our understanding of life and death. Our being together in some way made us whole. That rites of the celebration of life and death allowed us to feel complete, sound, healed.

What will allow us in nursing education to celebrate the sense of being complete, sound, healed? This journey really started with that quest; a question about the meaning of relationships in the context of nursing. The nurses who have responded to this question with the stories of their lives have told us that relationships are at the heart of their professional practice. Some types of relationship drain their energy, constrain the possibilities of their work. Other relationships enable them, give them the energy to engage others in the joy and pain that is nursing.

Yes, the reflection on these narratives has helped me to better understand this undeniable quality of our human existence. For me personally, the journey continues as I live in nursing with students and colleagues. The voices of nurses in practice call to us.

REFERENCES

Aoki, T. T. (1991). Pedagogical storying/theming: Toward practitioners' understanding of teaching through narratives. Unpublished paper presented in a graduate seminar, University of Alberta.

Baert, R. (1990, Summer). Enchantment/disturbance. On the Border. An occasional publication from Banff Centre for the Arts. p.6.

Bateson, M. C. (1989). Composing a life. New York: Plume Publishing.

Belenky, M. F., Clinchy, B. M., Goldberger, N. R., & Tarule, J. M. (1986). Women's ways of knowing: Development of self, voice and mind. New York: Basic Books.

Benhabib, S. (1987). The generalized and the concrete other. In S. Benhabib & D. Cornell (Eds.), Feminism as critique. Minneapolis: University of Minnesota Press.

Benner, P. (1984). From novice to expert. Menlo Park, CA: Addison-Wesley.

Benner, P., & Wrubel, J. (1989). The primacy of caring. Menlo Park, CA: Addison-Wesley.

Berman, M. (1989). Coming to our senses : Body and spirit in the hidden history of the west. New York: Simon and Schuster.

Bevis, E. O., & Watson, J. (1989). Toward a caring curriculum: A new pedagogy for nursing. New York: National League for Nursing.

Bordo, S. (1990). Feminism, postmodernism, and gender-scepticism. In L. J. Nicholson (Ed.), Feminism/postmodernism. New York: Routledge.

Borgmann, A. (1992). Crossing the postmodern divide. Chicago: University of Chicago Press.

Butterfield, H. (1965). The Whig interpretation of history. New York: W. W. Norton and Company.

Caputo, J. (1987). Radical hermeneutics. Bloomington: Indiana University Press.

Caputo, J. (1988). Beyond aestheticism: Derrida's responsible anarchy. Research in Phenomenology, 18, 59-73.

Caputo, J. (1989). Disseminating originary ethics. In A. B. Dallery & C. E. Scott (Eds.), The question of the other. Albany: State University of New York Press.

Carper, B. (1986). The ethics of caring. In P. Chinn (Ed.), Ethical issues in nursing. Rockville, MD: Aspen Systems.

Chinn, P. L., & Jacobs M. K. (1987). Theory and nursing: A systematic approach. St Louis: C.V. Mosby.

Cockburn, C. (1985). Machinery of dominance: Women, men and technical know-how. London: Pluto Press.

Crosby, C. (1991). The ends of history: Victorians and "the woman question". New York: Routledge Chapman and Hall.

Crowley, M. (1989). Feminist pedagogy: Nurturing the ethical ideal. Advances in Nursing Science, 11(3), 53-61.

Daly, M. (1978). *Gyn/ecology*. Boston: Beacon Press.

Flax, J. (1990). *Thinking fragments: Psychoanalysis, feminism and postmodernism in the contemporary west*. Berkeley: University of California Press.

Fox-Keller, E. (1985). *Reflections on gender and science*. London & New Haven: Yale University Press.

Fry, S. (1989). Toward a theory of nursing ethics. *Advances in Nursing Science*, *11*(4), 9-22.

Gadamer, H. G. (1975). *Truth and method*. London: Sheed and Ward.

Gadow, S. (1987). Nurse and patient: The caring relationship. In A. H. Bishop & J. R. Scudder (Eds.), *Caring, curing, coping: Nurse, physician, patient relationships*. Birmingham, AL: University of Alabama Press.

George, T., & Larsen, J. (1988). The culture of nursing. In A. J. Baumgart & J. Larsen (Eds.), *Canadian nursing faces the future*. St. Louis: C. V. Mosby.

Giddens, A. (1984). *The constitution of society: Outline of the theory of structuration*. Berkeley: University of California Press.

Giddens, A. (1991). *Gidden's theory of structuration: A critical appreciation*. Christopher Bryant & David Jary (Eds.). London: Routledge.

Gilligan, C. (1982). *In a different voice*. Cambridge: Harvard University Press.

Gilligan, C., Ward, J., Taylor, V., McLean, J., & Bardige, B. (Eds.). (1988). *Mapping the moral domain*. Cambridge: Harvard University Press.

Grimshaw. J. (1986). *Philosophy and feminist thinking*. Minneapolis: University of Minnesota Press.

Grumet, M. (1989). *Bitter milk: Women and teaching*. Amherst: University of Massachusetts Press.

Hedin, B. (1989). Nursing, education, and sterile ethical fields. *Advances in Nursing Science*, *11*(3), 43-52.

Heidegger, M. (1982). *On the way to language*. Trans: Peter Hertz. San Francisco: Harper and Row.

Heilbrun, C. G. (1990). What was Penelope unweaving? In *Hamlet's mother and other women*. New York: Ballantine Books.

Holmes, C. A. (1990). Alternatives to natural science foundations for nursing. *International Journal of Nursing Studies*, *27*(3), 187-198

Iachetta, L. (1993). *Unmasking fear*. Unpublished paper.

Kristeva, J. (1986). *The Kristeva reader*. Toril Moi (Ed.). New York: Columbia University Press.

Levin, D. M. (1989). *The listening self: Personal growth, social change and the closure of metaphysics*. London: Routledge.

Lorde, A. (1984). Sister outsider. Trumansburg, New York: The Crossing Press.

Leininger, M. M. (1988). Leininger's theory of nursing: Cultural care diversity and universality. Nursing Science Quarterly, 1(4), 152-160.

Merleau-Ponty, M. (1973). Prose of the world. Evanston: Northwestern University Press.

Murdoch, I. (1970). The sovereignty of good. London: Routledge and Kegan Paul.

Nicholson, L. (1990). Feminism/Postmodernism. New York: Routledge.

Noddings, N. (1984). Caring: a feminine approach to ethics and moral education. Berkley and Los Angeles: University of California Press.

Olkowski-Laetz, D. (1989). Space, time, and the sublime. In A. B. Dallery & C. E. Scott (Eds.), The question of the other. Albany: State University of New York.

Oxford English Dictionary (1971). The compact edition. Oxford University Press.

Parse, R. (1981). Man-living health: a theory of nursing. New York: John Wiley.

Ricoeur, P. (1981). The hermeneutical function of distanciation. In J. B. Thompson (Ed. & Trans.), Hermeneutics and the human sciences (pp. 131-144). Cambridge: Cambridge University Press (Reprinting from Philosophy Today, 1973, 17, 129-143).

Roderick, L. (1991). Thinking like a mountain (Cassette Recording). Anchorage, AK: Turtle Island Records.

Rosenau, P. M. (1992). Post-modernism and the social sciences: Insights, inroads and intrusions. Princeton, NJ: Princeton University Press.

Singer, L. (1989). Defusing the canon: Feminist rereading and textual politics. In A. B. Dallery & C. E. Scott (Eds.), The question of the other. Albany: State University of New York Press.

Smith-Rosenberg, C. (1985). Hearing women's words: A feminist reconstruction of history, in disorderly conduct: Visions of gender in Victorian America. New York: Alfred A. Knopff, pp. 11-52.

Spelman, E. (1988). Inessential woman. Boston: Beacon Press.

Thompson, J. L. (1985). Practical discourse in nursing: going beyond empiricism and historicism. Advances in Nursing Science, 7(4), 59-71.

Tomm, W. (1993). Personal communication.

Tufts, H. (1990). Filmmakers Robin J. Hood and Penny Joy. Canadian Woman Studies, 2(1), 94-96.

Van Manen, M. (1984). Practicing phenomenological writing. Phenomenology & Pedagogy, 2, 36-69.

Watson, J. (1985). Nursing: Human science and human care. New York: Appleton-Century-Crofts.

Wolfer, J. (1993). Aspects of "reality" and ways of knowing in nursing: In search of an integrating paradigm. Image: Journal of Nursing Scholarship, 25, 141-146.